CAMP HILL (Main Office/Billing Address)
207 House Ave, Suite 109
Camp Hill, PA 17011

LifeSpire, LLC
www.LifeSpirePA.com
717-745-6166

HERSHEY
523 W. Chocolate Ave, 2nd Floor
Hershey, PA 17033

Adolescent Group Information Sheet

Adolescent group participant should fill out pages 1 & 2.
Parent of adolescent group participant should fill out pages 3 & 4.

Name: ________________________ **Age**: ________ **Date of Birth**: ______________

Address: ____

Home Phone: ____________________ **Cell/Work Phone**: ____________________

Mother's Name: ____________________ **Occupation**: ____________________

Father's Name: ____________________ **Occupation**: ____________________

Parents' Relationship Status:
☐ Never Married ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widow / Widower

Who is your LifeSpire clinician? ____

Please list anyone living in the home with your child:

Name	Age	Relationship to you	Occupation

Briefly describe what you think the group should focus on:

How would you describe your academic performance?
☐GOOD ☐AVERAGE ☐POOR

Describe your religious or spiritual orientation? ________________________________

MENTAL HEALTH BACKGROUND OF ADOLESCENT

Please list any previous mental health treatment and/or substance abuse treatment:

Treatment Dates	Name of Provider/Agency	Reason for Treatment	Treatment Success

At this time, do you have thoughts of self-harm? ☐ YES ☐ NO
Have you ever attempted suicide? ☐ YES ☐ NO
At this time, do you ever think of harming others? ☐ YES ☐ NO
Do you have any allergies or sensitivities to drugs, food, or other substances? ☐ YES ☐ NO
Do you smoke or use other tobacco products? ☐ YES ☐ NO
Do you drink alcohol? ☐ YES ☐ NO
Do you use recreational drugs (marijuana, cocaine, or other drugs)? ☐ YES ☐ NO

What are you hoping this group will be like?

If you have had group therapy in the past, please describe your experience below:

Are there any group dates you will be unavailable to attend? Please list

If there is any other information that you believe would be helpful for me to know, please describe below:

CAMP HILL (Main Office/Billing Address)
207 House Ave, Suite 109
Camp Hill, PA 17011

LifeSpire, LLC
www.LifeSpirePA.com
717-745-6166

HERSHEY
523 W. Chocolate Ave, 2nd Floor
Hershey, PA 17033

Parent Complete Pages 3 & 4

MEDICAL HISTORY

Primary Care Physician or Provider:

Name: ____ **Phone:** ____________________

Address: ____

How would you describe your child's physical health?

☐Excellent ☐Good ☐Average ☐Poor ☐Very Poor

List any of your child's medical conditions:

Please list any medications your child is taking (prescription or over-the-counter)

Medication/Drug	Dose/Frequency	When started	For what symptoms

DEVELOPMENTAL HISTORY

Did the mother experience any potentially serious health problems during pregnancy, such as high blood pressure, toxemia, RH incompatibility, measles, etc.? ☐ YES ☐ NO

Was your child born prematurely? ☐ YES ☐ NO

What was your child's weight at birth? __________pounds __________ounces

Did your child experience any difficulties at birth, such as breathing problems, oxygen deprivation, use of incubator, etc.? ☐ YES ☐ NO

CAMP HILL (Main Office/Billing Address)
207 House Ave, Suite 109
Camp Hill, PA 17011

LifeSpire, LLC
www.LifeSpirePA.com
717-745-6166

HERSHEY
523 W. Chocolate Ave, 2nd Floor
Hershey, PA 17033

Please check early, on time, or late in terms of developmental milestones of your child:

	EARLY	ON TIME	LATE
Sit up	☐	☐	☐
Crawl	☐	☐	☐
Talk	☐	☐	☐
Walk	☐	☐	☐
Toilet Training	☐	☐	☐

Education Grade Level: ____________ **Educational Placement**: ____

Current School: ____

How would you describe your child's academic performance?

☐GOOD ☐AVERAGE ☐POOR

If there is any other information that you believe would be helpful for me to know, please describe below: