

Lois Thomson-Bowersock & Associates, LLC

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New Client Profile - Adolescent

Name: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

Fax: _____ Cell: _____

Date of Birth: _____ Age: _____

Gender: _____ Social Security No: _____

School Grade: _____

Family Status (single parent, blended, traditional or other): _____

Who has custody? _____

Currently under the care of a physician? Yes _____ No _____

Physician's Name: _____ Telephone: _____

Chronic or ongoing medical conditions:

If so, please explain:

What medications is client taking? (include over-the-counter medications):

Emergency Contact:

Name: _____ Telephone: _____

Parent / Guardian Information:

Name: _____

Relationship to Client: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

Cell: _____ Fax: _____

Email: _____

Social Security No. _____ Birth Date: _____

Marital Status: _____

Employer: _____

Employer's Address: _____

Person who referred you:

Name: _____ Telephone: _____

Client Information:

Prior psychological or chemical dependency counseling/treatment: Yes _____ No _____

If yes, please explain:

Nature of presenting problem?

Alcohol or drug use? Yes _____ No _____

Tobacco? Yes _____ No _____

Caffeine: Yes _____ No _____

Substance(s) Used	Frequency Used	Amount Used

Consent for Evaluation:

I hereby agree to the performance of an interview and the collection of information deemed necessary by Lois Thomson-Bowersock & Associates, LLC, to evaluate my problems/needs and make appropriate recommendations.

Adolescent Signature

Date: _____

Guardian Signature

Date: _____