ADOLESCENT BIOGRAPHICAL INFORMATION FORM

Please fill out this form as completely as possible, noting pages 1-5 are for the client to fill out while pages 6-10 are for the parent to fill out. All information is confidential as outlined in the Disclosure Form. If you wish not to answer any question, you may write "Do not care to answer." Please bring this form to the first session.

Before you start, I want you to know that this information is very helpful in our work together. I recognize that it may be difficult to disclose so much to me and I want to thank you in advance for trusting me with this information. If you have questions for me, feel free to write them on the back of this packet.

Date_____

PERSONAL & FAMILY INFORMATION

Name_____Age_____Birthdate_____/_____/_____

Address_____

Phone numbers (c)_____(h)_____

Email Address _____

School and grade: _____

Mother's name _____

Brief statement on you relationship with this parent: _____

_____

Father's name _____

Brief statement on you relationship with this parent: _____

_____

Step-parent name (if applicable): _____

Brief statement on you relationship with this step-parent: _____

_____

Step-parent name (if applicable): _____

Brief statement on you relationship with this step-parent: _____

_____

Marital status of parents: _____

Marriage/divorce dates: _____

If your parents are divorced, whom do you primarily live with? _____

How often do you see each parent? Mom_____% Dad _____%

Do you think your parents relationship is healthy? □ Yes □ No □ Unsure

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Siblings (name, age, & brief statement of your relationship with this person):

1. _____
2. _____
3. _____

FAMILY CONCERNS

	fighting (verbally)		education problems		job change or job dissatisfaction
	fighting (physically)		financial problems		disagreeing about relatives
	loss of fun		death of a family member or pet		disagreeing about friends
	lack of honesty		abuse or neglect		alcohol use
	physical fights		inadequate houseing/feeling unsafe		drug use
	infidelity		issues regarding re-marriage		inadequate health insurance
	feeling distant		birth of a sibling		birth of a child

Other family concerns not listed above: _____

_____

Is there a family history of substance abuse, mental illness, eating disorders, or violence?

_____

_____

MEDICAL/COUNSELING INFORMATION

Medical doctors (name/phone): _____

Any past or present medical care that would be helpful for me to know about? _____

_____

Are you currently or have you ever been on medication for your mental health? _____

_____

Have you been in counseling in the past? ☐ Yes ☐ No

If yes, what did you find *most* helpful in counseling? _____

_____

If yes, what did you find *least* helpful in counseling? _____

_____

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Do we have your permission to discuss or receive treatment records and/or to receive diagnostic records from your past or current therapist, psychiatrist, and/or physician and/or to disclose or share our clinical information with your past or current therapist, psychiatrist,and/or physician? ☐ Yes ☐ No

Signature (if 16 or older) _____

Signature of parent (if 15 or younger) _____

SOCIAL INFORMATION

Please share social media that you use (Facebook, Instagram, Snap Chat, Twitter, etc):

_____

Do your parents have access to your social media use/emails/texts? ☐ Yes ☐ No

Do your parents have any issues with your use of social media/email/texts? _____

_____

How do you consider yourself socially? ☐ Outgoing ☐ Shy ☐ Depends on situation

Are you happy with the amount of friends you have? ☐ Yes ☐ No

Have you ever been bullied? ☐ Yes ☐ No

Are your parents happy with your friends? ☐ Yes ☐ No

Are you involved in any organizations, sports, clubs, etc.? _____

SCHOOL HISTORY

Do you like school? ☐ Yes ☐ No

Do you attend school regularly? ☐ Yes ☐ No

What types of grades do you usually earn? _____

Do you feel you are doing the best you can in school? ☐ Yes ☐ No

PERSONAL INFO

Please state briefly why you are seeking counseling at this time: _____

_____

_____

What are your goals for counseling? _____

_____

_____

What would you like to be different after you're done with counseling? _____

_____

_____

Were there any events or accidents in your life that you feel were traumatic? _____

_____

Do you now, or have you every, had an eating disorder or body image challenges? _____

_____

What activities do you enjoy and feel you are successful at when you try? _____

_____

What are your strengths? _____

_____

What are your fears? _____

_____

Favorite sports? _____

Favorite leisure time activities? _____

Religious/spiritual beliefs? _____

Hero/role models? _____

Do you like being alone or with friends? _____

How well do you get along with your friends? _____

Favorite people? _____

SUBSTANCE USE & HISTORY

Do you currently use alcohol? □ Yes □ No

If yes, how often do you drink? □ Daily □ Weekly □ Occasionally □ Rarely

If yes, how much do you drink? _____ (#) per time

Do you currently use tobacco? □ Yes □ No

If yes, how much do you smoke/chew? _____

Do you currently use any other substances? □ Yes □ No

If yes, what drugs do you use? _____

If yes, how often do you use? □ Daily □ Weekly □ Occasionally □ Rarely

Have you ever received any treatment for drug or alcohol use? □ Yes □ No

If yes, list where you went and dates: _____

Have you ever used more than one substance at the same time to get high? □ Yes □ No

Do you avoid family activities so you can use? □ Yes □ No

Do you have a group of friends who also use? □ Yes □ No

Do you use to cope with your emotions (such as feeling sad, lonely, or bored?) □ Yes □ No

INDIVIDUAL CONCERNS

Are you experiencing:	None	Mild	Moderate	Severe	Are you experiencing:	None	Mild	Moderate	Severe
sadness					elevated mood				
crying					mood swings				
sleep disturbances					disorganized				
problems at home					phobias				
hyperactivity					grief				
binging/purging					anorexia				
loneliness					headaches				
unresolved guilt					weight changes				
irritability					appetite changes				
nausea					social isolation				
social anxiety					paranoid thoughts				
self-mutilation					poor concentration				
cutting					indecisiveness				
impulsivity					easily distracted				
nightmares					excessive worry				
hopelessness					low self-worth				
anger issues					hallucinations				
spiritual concerns					racing thoughts				
drug use					restlessness				
alcohol use					low energy				
trauma flashbacks					obsessive thoughts				
panic attacks					feeling anxious				
feeling panicky					genital problems				
fatigue					tension/stress				
temper control					parents' relationship				
suicidal thoughts					suicide attempt				

List any other concerns not listed above: _____

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ADOLESCENT INTAKE FORM (PARENT SECTION)

Adolescent's name: _____

Date of birth: _____ Age: _____

Who to call in case of emergency: _____phone: _____

CURRENT HOUSEHOLD INFORMATION

NAME	RELATIONSHIP	AGE	GENDER	TYPE (biological,step, etc.)	LIVING WITH THE CLIENT? YES/NO

(If additional space is needed, please use back of page)

CURRENT REASON FOR COUNSELING

Briefly describe the problem for which your adolescent is seeking counseling for?

_____

_____

_____

What would you like to see happen as a result of counseling? _____

_____

_____

What is most concerning right now? _____

_____

_____

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CHILD'S DEVELOPMENT

1. Were there any complications with the pregnancy or birth of your child? □ Yes □ No

If yes, describe: _____

2. Did your child have health problem at birth? □ Yes □ No

If yes, describe: _____

3. Did your child experience any developmental delays?

If yes, describe: _____

4. Did your child have any unusual problems or behaviors before age 3?

If yes, describe: _____

5. Has your child experienced emotional, physical, or sexual abuse?

If yes, describe type of abuse, age of onset, and if a report was made to authorities: _____

_____

_____

COUNSELING & MEDICAL HISTORY

1. Has your child been in counseling in the past? □ Yes □ No

If yes, where did your child go and what were the approximate dates? _____

If yes, what was the reason for counseling? _____

If yes, what did you find *most* helpful in counseling? _____

_____

If yes, what did you find *least* helpful in counseling? _____

_____

Has your child received psychiatric services? □ Yes □ No

If yes, who did they see? _____

If yes, was it helpful? □ Yes □ No □ Unsure

Does your child have other medical concerns or hospitalizations? □ Yes □ No

If yes, describe: _____

SUBSTANCE USE

Do you have any concerns about your child using drugs or alcohol? ☐ Yes ☐ No

If yes, describe: _____

Does your child live with anyone who abuses drugs or alcohol? ☐ Yes ☐ No

If yes, describe: _____

INTERNET & SOCIAL MEDIA CONCERNS

Do you have any concerns with your child using social media (such as Facebook, Twitter, Instagram, Snap Chat, etc.) or texting? ☐ Yes ☐ No

If yes, describe: _____

_____

LEGAL ISSUES

Please list any legal issues that are affecting you, your family or your child presently or in the past: _____

_____

FAMILY HISTORY

Are you aware of any birth trauma or relational trauma your child experienced from birth to age 3? _____

_____

Have you experienced any abuse (physical, emotional, or sexual)? Please share as much as you feel comfortable. _____

_____

BIOLOGICAL PARENT'S MARITAL STATUS

☐ Single ☐ Married ☐ Cohabitating ☐ Separated Widowed ☐ Other:

☐ Divorce in progress ☐ Divorced, age of child at time of divorce: _____

Length of marriage/relationship: _____

Biological Mother's name _____
Occupation _____
Address _____
Phone numbers (c) _____ (h) _____ (w) _____
Email address _____

Biological Father's name _____
Occupation _____
Address _____
Phone numbers (c) _____ (h) _____ (w) _____
Email address _____

FAMILY CONCERNS

	fighting (verbally)		education problems		job change or job dissatisfaction
	fighting (physically)		financial problems		disagreeing about relatives
	loss of fun		death of a family member or pet		disagreeing about friends
	lack of honesty		abuse or neglect		alcohol use
	physical fights		inadequate houseing/feeling unsafe		drug use
	infidelity		issues regarding re-marriage		inadequate health insurance
	feeling distant		birth of a sibling		birth of a child

Other concerns not listed above: _____

_____

What are your child's strengths? _____

_____

What are your child's fears? _____

_____

Please describe some of the influential and supportive people, activities, or beliefs in your child's life? _____

_____

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INDIVIDUAL CONCERNS YOU HAVE FOR YOUR CHILD

Are you experiencing:	None	Mild	Moderate	Severe	Are you experiencing:	None	Mild	Moderate	Severe
Sadness					elevated mood				
Crying					mood swings				
Sleep disturbances					disorganized				
problems at home					phobias				
hyperactivity					grief				
binging/purging					anorexia				
loneliness					headaches				
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