



Young Adult Background Information

A. Identification

Patient Name _____ Birthdate: _____ Age: _____

Parent/Guardian Name: _____

Patient is living with:

- Both parents Mother Father Grandparent(s)
 Mother & Stepfather Father & Stepmother Legal Guardian
 Other: _____

Status of parents' marriage:

- Married Separated Divorced Widowed Single
How long married? _____ How long divorced? _____ Child's age at divorce: _____

B. Chief concern

Please describe the main difficulty that has brought the patient to therapy:

C. Treatment History

1. Has the patient ever received psychological or psychiatric or counseling services before?

No Yes If yes, please indicate:

When?	From whom?	For what?	With what results?
_____	_____	_____	_____
_____	_____	_____	_____

2. Has the patient taken medications for psychiatric or emotional problems? No Yes If yes indicate:

When?	From whom?	Which medications?	For what?	With what results?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

3. Describe any significant physical health problems/concerns:

(cont.)

D. Relationships. Please describe the following:

1. List the people who live at home:

Name:	Age:	Relationship to patient:	Occupation:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. Relationship between adults in the home:

2. Patient's relationship with each parent and with other adults present:

3. Patient's relationship with brothers and sisters, in the past and present:

4. Please provide any other information about extended family that might help us understand the patient's needs (e.g., medical, developmental, behavioral, educational, emotional, or psychological):

5. Patient's important friends, past and present:

Names	Good parts of relationship	Bad parts of relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(cont.)

5. Patient relationship with their own child/children if applicable:

E. Educational History:

Current grade: _____ Name of School: _____

Type of school: Public Private Home School Special/Alternative Program

Extracurricular activities? Please list _____

Do you feel the patient is learning up to his or her potential? Yes No

If no, please indicate the academics areas that are underdeveloped:

- Mathematics: Problems with acquisition of mathematical facts Careless errors
 Difficulty performing simple arithmetic (e.g., addition, subtraction, division)
 Difficulty understanding word-problems Other: _____
- Reading: Difficulty matching letter sounds to written symbols
 Difficulty pronouncing words (especially long ones)
 Reading is "choppy" or non-fluent
 Difficulty with reading comprehension Other: _____
- Writing: Illegible writing Inconsistent spacing / inconsistent handwriting
 Difficulty expressing ideas in writing poor spelling
- Language: difficulty finding words to name objects takes a long time to get a thought across
 difficulties understanding or following directions even when paying attention
 Other: _____

Please check any other concerns or problems the patient has in school:

- Does not do homework Excessive time to complete assignments Distracted
 Poor handwriting Forget assignments Test Anxiety
 Does not remain seated Starts but does not finish homework Excessive talking
 Noncompliant in class Incomplete classroom work Careless errors
 Fails to check homework Poor attention in class Messy/disorganized

Has the patient been retained a grade? Yes No. If yes, which grade? _____

Were there any concerns regarding learning or behavior? Yes No

Has the patient been placed in special education programs currently or in the past? Yes No

Does the patient have:

1. Learning disability (LD): Yes No. Subjects: _____

2. Language disorder: Yes No. Type: _____

3. Tutoring: Yes No. Where: School Other: _____

4. Receiving special education/ 504 / Other Health Impaired (OHI) services? Yes No

(cont.)

F. Abuse history: Patient was not abused in any way. Patient was abused. If the patient was abused, please indicate the following: For kind of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect you. E = Emotional, such as humiliation, etc.

Patient age	Kind of abuse	By whom?	Effects on patient?	Who was told?	Consequences of telling?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Other than those listed above, please list any unusual, traumatic, or possibly stressful events in the patient's life that you think may have had an impact on development and/or current functioning. Include incident, patient's age at the time, and comments:

G. Chemical use

1. Has the patient ever needed to cut down on alcohol/substance use? No Yes
2. Has the patient ever felt annoyed by criticism of their alcohol/substance use? No Yes
3. Has the patient expressed/felt guilt about alcohol/substance use? No Yes
4. Has the patient ever used alcohol or another substance to get the day started? No Yes
5. How much beer, wine, or hard liquor does the patient consume each week, on average? _____
6. How much tobacco does the patient smoke or chew each week? _____
7. Which drugs (not medications prescribed for you) has the patient used?

Please provide details about use of these drugs or other chemicals, such as amounts, how often used, their effects, and so forth: _____

I. Other

Is there anything else that is important for the therapist to know about, that has not yet been asked or expressed? If yes, please explain here:
