



## 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:

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### 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?

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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?

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3. Describe any significant physical health problems/concerns:

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(cont.)

**D. Relationships.** Please describe the following:1. List the people who live at home:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Occupation: \_\_\_\_\_

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2. Relationship between adults in the home:

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

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

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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):

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

Names

Good parts of relationship

Bad parts of relationship

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(cont.)

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

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**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:

<input type="checkbox"/> Does not do homework	<input type="checkbox"/> Excessive time to complete assignments	<input type="checkbox"/> Distracted
<input type="checkbox"/> Poor handwriting	<input type="checkbox"/> Forget assignments	<input type="checkbox"/> Test Anxiety
<input type="checkbox"/> Does not remain seated	<input type="checkbox"/> Starts but does not finish homework	<input type="checkbox"/> Excessive talking
<input type="checkbox"/> Noncompliant in class	<input type="checkbox"/> Incomplete classroom work	<input type="checkbox"/> Careless errors
<input type="checkbox"/> Fails to check homework	<input type="checkbox"/> Poor attention in class	<input type="checkbox"/> 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:

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#### 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: \_\_\_\_\_

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#### 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:

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