

BACKGROUND INFORMATION FORM

Adolescent (Ages 13-18)
(Completed by Parent/Guardian)

Instructions: To assist in helping you and your teen, please fill out this form as fully and openly as possible. All of the information on this form is held in the strictest confidence within legal limits. If certain questions do not apply, leave them blank.

Name of Teen: _____ Age: _____ Date of Birth: _____ Gender: M/F

Parent/Guardian Providing History: _____

School: _____ Grade: _____

Who referred you? _____

Presenting Problem(s):

What has caused you to seek therapy for your teen at this time? _____

How long have these problems occurred? (number of weeks, months or years) _____

Problems perceived to be: Very serious Serious Not serious

Symptoms: (check **ALL** that apply and rate severity of each from 1-5; 1 = least severe 5 = most severe):

- | | | | |
|---|---|--|---|
| <input type="radio"/> Very unhappy | <input type="radio"/> Irritable | <input type="radio"/> Anger outbursts | <input type="radio"/> Withdrawn/isolates self |
| <input type="radio"/> Fearful/worries/anxious | <input type="radio"/> Overactive | <input type="radio"/> Short attention span | <input type="radio"/> Distractible |
| <input type="radio"/> Lacks confidence | <input type="radio"/> Peer conflict | <input type="radio"/> Phobic | <input type="radio"/> Impulsive |
| <input type="radio"/> Defiant | <input type="radio"/> Mean to others | <input type="radio"/> Destructive | <input type="radio"/> Trouble with the law |
| <input type="radio"/> Running away | <input type="radio"/> Self-injury | <input type="radio"/> Shy | <input type="radio"/> Stealing |
| <input type="radio"/> Lying | <input type="radio"/> Truancy | <input type="radio"/> Argues/back talk | <input type="radio"/> Poor school performance |
| <input type="radio"/> Eating problems | <input type="radio"/> Sleeping problems | <input type="radio"/> Drug use | <input type="radio"/> Alcohol use |
| <input type="radio"/> Suicide talk | | | |

What are your expectations of your teen? _____

What changes would you like to see in your teen? _____

List your teen's greatest strengths:

List your teen's greatest challenges or needed areas of improvement:

List specific behaviors you would like to see change:

Family History

Mother's Name: _____

Mother's Occupation: _____

Describe the teen's relationship(s) with his/her mother:

Father's Name: _____

Father's occupation: _____

Describe the teen's relationship(s) with his/her father:

Parent's marital status:

Married for ____ # of years Never married Separated Divorced Widowed

If mother or father is deceased, please indicate when and the age of the teen at the time: _____

If separated or divorced, for how long? _____

Please describe the details of the custody arrangement. Is custody joint or does one parent have primary custody: _____

If remarried, for how long? _____

Step-parent (s) name(s): _____

Step-parent(s) occupation(s): _____

Describe the teen's relationship(s) with her/her step-parent(s):

List all siblings, including those by previous and subsequent marriages and any deceased children with date of death:

Name	Age	Grade or Occupation	Household? Yes or No	Relationship to Teen (full/half/step)

Describe the teen's relationship with his/her siblings:

Educational/Social History

For each grade, indicate where the teen went to school and note any school concerns or positive experiences.

	School	Concern/Positives
Preschool/Daycare/Headstart		
Kindergarten		
Grades 1 thru 3		
Grades 4-6		
Grades 7-8		
Grades 9-12		

Has your teen repeated any grades? Yes No If yes, what grade(s)? _____

Has the teen ever been tested or involved in any type of special education/supplementary program, if so, what grade(s) did they participate or when did the testing occur?

Program	Yes/No	Grade(s)
Learning disabilities		
Emotional/behavior disorders		
Speech & language therapy		
Occupational therapy		
Adaptive education		

What grades does your teen usually receive? _____

Have these changed lately? Yes No If yes, how? _____

In which school subjects does your teen excel? _____

Which school subjects are most challenging to your teen? _____

Briefly describe your teen's friendships:

What hobbies and extra-curricular activities does your teen enjoy?

Has your teen had a job? Yes No

If **yes**, what kind? _____

What kind of experience has this been? _____

Developmental/Medical History:

Prenatal History:

How was the mother's overall health during pregnancy?

Good Fair Poor Don't know

Did the teen's mother experience any medical problems or complications during the pregnancy?

Yes No If **yes**, explain: _____

List any drugs (including alcohol) used by the mother or father at the time of conception, or by the mother during pregnancy:

1. _____
2. _____
3. _____
4. _____

How would you describe your teen as a baby?

Were there any health problems during infancy and toddler years? Yes No, If **yes**, explain: _____

Developmental Milestones:

In the past, have you or anyone else had concerns about this teen's childhood development? Yes No If **yes**, please explain: _____

Medical Information:

Name & Address of teen’s Physician(s):

Physician’s Name: _____

Address: _____

May we contact this provider in order to help coordinate care? Yes No If **yes**, please sign release on our consent page.

How would you describe this teen’s current health?

Very good Good Fair Poor Very poor

List any physical concerns occurring at present (headaches, dizziness, stomachaches, etc – indicate if chronic): _____

Has your teen ever taken medication for emotional, physical, learning or behavioral problems? Yes No

What medications (and dosages) is your teen taking at present and for what purpose?

	Medication	Dose	Purpose	How Long
1.				
2.				
3.				
4.				

Describe this teen’s sleep patterns (rate severity 1-5: 1 = least severe, 5 = most severe):

Sleeps all night without disturbance Difficulty falling asleep Sleeps too much
 Awakens during the night/restless sleeper Early morning awakening

Describe the teen’s appetite (during the past month):

Poor appetite Average appetite Large appetite

Has there been a significant change in weight in the past month? Yes No

Describe this teen’s current activity/energy level:

Hyperactive Active/Alert Normal for age Underactive/lethargic

To the best of your knowledge, does or has your teen ever used alcohol or other non-prescription medication? Yes No

If **yes**, what/how much? _____

Is there a family history of alcoholism or chemical dependency? Yes No If **yes**, briefly explain: _____

Is there a family history of mental illness? Yes No If **yes**, briefly explain: _____

Is there a family history of domestic violence? Yes No If **yes**, briefly explain: _____

Is there a history or recent occurrence(s) of child abuse to this teen? Yes No
If **yes**, which type(s) of abuse: Verbal Physical Sexual

Comments: _____

Have you ever had any concerns about your teen being suicidal or trying to hurt themselves or others? Yes No
If **yes**, briefly explain: _____

Are finances a concern for your family? Yes No If **yes**, explain: _____

Mental Health Service History:

Is your teen currently receiving counseling/psychiatric/case management services elsewhere? Yes No
If **yes**, who is the provider (name and clinic or agency): _____

Has your child or family received any of these services in the past? Yes No
If **yes**, with which provider(s): _____

Changes or Stressful Events:

Indicate which if any of the following changes or stressful events have been experienced by your teen in the past year:

- Changes in residence
- Change in schools
- Job changes of parent(s)
- Changes in financial status
- Family accident or illness
- Death/loss of family member(s), friends or pets
- Divorce/separation
- Family violence
- Legal arrests, imprisonment, lawsuits
- Victim of verbal, physical or sexual abuse
- Foster care or other similar placements of family members outside of home

Briefly describe those that apply:

Legal Involvement:

Is your teen or family currently involved in any legal difficulties (facing charges, involved in lawsuits, on probation, child protection, etc?) Yes No If **yes**, briefly explain: _____

Nutrition:

Nutrition is very important to a person’s physical health and mental well-being. This is a simple screen to help us determine any nutritional risks your teen may have.

Does/has your teen:

- | | | |
|--|---------------------------|--------------------------|
| 1. Eat breakfast most mornings? | <input type="radio"/> Yes | <input type="radio"/> No |
| 2. Eat lunch at school? | <input type="radio"/> Yes | <input type="radio"/> No |
| 3. Does your family eat meals together most days? | <input type="radio"/> Yes | <input type="radio"/> No |
| 4. Exercise daily? | <input type="radio"/> Yes | <input type="radio"/> No |
| 5. Eat a balanced diet including a variety of food and adequate amounts (such as 3-5 servings of fruits & vegetables per day and 2-3 servings of milk) | <input type="radio"/> Yes | <input type="radio"/> No |
| 6. Lost or gained over 10 pounds in the last 6 months without trying? | <input type="radio"/> Yes | <input type="radio"/> No |
| 7. Suspect that he/she may have an eating disorder? | <input type="radio"/> Yes | <input type="radio"/> No |
| 8. Spend more than 4 hours with the TV or computer each day? | <input type="radio"/> Yes | <input type="radio"/> No |
| 9. Have any special dietary needs? (i.e. pregnancy, diabetes, allergies, etc.) | <input type="radio"/> Yes | <input type="radio"/> No |
| 10. Take herbal supplements or other over-the-counter medications? | <input type="radio"/> Yes | <input type="radio"/> No |

Please list any other concerns about your teen’s diet that we should know about: _____

Additional Comments: