Phone (541) 423-8151 Fax (541) 423-8508

INTAKE/BIOPSYCHOSOCIAL HISTORY FORM - ADOLESCENT

Please provide the following information and answer the questions below. Please note: information you provide here is protected as **confidential** information.

Please fill out this form and bring it to your first session.

Name: ____

(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

____

(Last) (First) (Middle Initial)

Birth Date: ______ /______ /______ Age: ________ Gender: □ Male □ Female

Address: ____

(Street and Number)

____

(City) (State) (Zip)

Home Phone: ( ) ______________________May we leave a message? □ Yes □ No

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Cell/Other Phone: ( )____________________May we leave a message? □ Yes □ No

E-mail: ____May we email you? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

With whom do you live? ____

Brought in for counseling by: ______________________________Relationship to you:___________

What school do you go to? ________________________________Grade: ________

Are you here because you want counseling or because someone else wants you to get counseling? □ I do □ Someone else does: ____

Referred by (if any): □ Doctor □ Family □ Friend □ Other _____________

Insurance Information

Insurance Company: ____________________ Policy#:____________________

Subscriber Name:_______________________Subscriber DOB:______________

Secondary Insurance Company:________________ Policy#:___________________

Subscriber Name:_______________________Subscriber DOB:______________

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GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Describe your current physical health: □ Excellent □ Good □ Average □ Poor □ Very Poor

Please list any health concerns: ____

Are you currently under a doctor's care?________ (If yes, please describe)_________________

____

Physician's Name:_______________________________ Address:_______________________

____

Please list any prescription and/or over-the-counter medication you are currently taking:

____

How would you rate your current sleeping habits?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please specify any sleep problems you are currently experiencing:
□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams
□ Other____

Are you having any difficulty with appetite or eating habits? □ Yes □ No

If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting □ Purging

Are you currently experiencing overwhelming sadness, grief, or depression? □ No □ Yes

If yes, for approximately how long? ____

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Are you currently experiencing anxiety, panic attacks, or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? ____

Have you previously received any type of mental health services (counseling, psychotherapy, psychiatric services)?

□ No □ Yes, previous therapist/practitioner: ______________________________

Please describe the experience and issues you covered in therapy: ________________________

____

Have you ever been prescribed psychiatric medication (For depression, anxiety, ADHD, etc.)?

□ No □ Yes - Please list and provide dates: ____

Have there been any traumatic events in your life? □ No □ Yes
If yes, please describe: ____
Have you ever been sexually abused? □ No □ Yes

Have you ever been physically abused? □ No □ Yes

Have any of the other children in your home been abused? □ No □ Yes

Have you ever witnessed violence between adults? □ No □ Yes

How would you describe your interactions with kids your own age?

____

____

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How would you describe your interactions with adults?

____

____

Have you gone through periods of major stress? □ No □ Yes

Are you using alcohol or other drugs? □ No □ Yes
If yes, please list: ____

Are you sexually active? □ No □ Yes

Have you had any legal problems (shoplifting, tagging, etc.)? □ No □ Yes ________________

ACADEMIC AND SOCIAL

How well do you do in school? ____

____

Do you like school? □ No □ Yes

Do you receive any special services (IEP, 504 Plan): ___________________________________

____

Are you satisfied with your current social life? Please explain:____________________________

____

Are you involved with any social groups, churches, activities, hobbies, sports teams, etc.?

____

FAMILY HISTORY

Your biological parents' names and ages: ____

____

Adults with whom you live:____

____

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List names and ages of biological brothers and sisters: ___________________________________

____

List names and ages of stepbrothers and sisters and other children living in the home:

____

____

Were you adopted? Yes _____ No ______   If yes, at what age: _____

Have you ever lived in foster care or a similar living arrangement? Yes _____ No _____
If yes, at what age(s): _____

How well are you doing with your home life?____

____

Has there been a death of a family member? Yes _____ No _____
If yes, what relationship was this person to you? ________________________________

In the section below, identify if there is a **family history** of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

		List Family Member
Alcohol/Substance Abuse	□ yes □ no	__________________
Anxiety	□ yes □ no	__________________
Depression	□ yes □no	__________________
Domestic Violence	□ yes □no	__________________
Eating Disorders	□ yes □no	__________________
Obesity	□ yes □no	__________________
Obsessive Compulsive Behavior	□ yes □no	__________________
Schizophrenia	□ yes □no	__________________
Suicide Attempts	□ yes □no	__________________

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PRESENTING PROBLEM(S)

In your own words, briefly describe the main problem which prompted you to seek counseling at this time:____

____

____

Please check any of the following that are currently troubling you. Put **two** checks by those items which are most important. You may add any comments you would like:
****Please note** that **intent** to harm yourself or another person cannot be protected as confidential information (cannot, by law, be kept secret by the counselor).

___Abortion/Adoption
___Adjustment Problems
___Anger/Temper
___Anxiety (worry)
___Child Abuse
___Concentration
___Death of a loved one
___Depression
___Failure
___Family Conflict
___Fear
___Friends
___Frustration
___Guilt
___Loneliness
___Loss of Interest
___Loss of Pleasure
___Memory Problems
___Panic
___Rape
___Rebellion
___Rejection
___Religious/Spiritual Issues
___Repetitive Ideas
___School Problems
___Sexual Abuse
___Self-Esteem
___Shy/Awkward
___Sleep Problems
___Suicide Attempt(s)
___Suicidal Thoughts
___Wish to Hurt Someone
___Withdrawal

Do you have thoughts of killing yourself or others? □ No □ Yes _____________________________

Do you harm yourself (cutting, burning, hair pulling, pinching)? □ No □ Yes If yes, how do you harm yourself and how often: ____

____
What are your strengths? ____

____

What would you like to accomplish out of your time in therapy? ______________________________

____