Counseling Center at Heritage
HELPING YOU FIND YOUR WAY

Adolescent Biography

***This form should be completed by or about the adolescent client.*

Client Information

Name: _____ Date: _____

Name of Person completing this form: _____

Symptoms:

**Please check off one box for each symptom, if symptom is not applicable check "None"*

Symptom	None	Mild	Mod	Severe	Symptom	None	Mild	Mod	Severe
Sadness					Low Self Worth				
Appetite Changes					Irritability				
Crying					Anger Issues				
Social Isolation					Nausea/Indigestion				
Sleep Disturbances					Social Anxiety				
Paranoid Thoughts					Restlessness				
Poor Concentration					Impulsivity				
Indecisiveness					Nightmares				
Binge Eating					Hopelessness				
Purging					Easily Distracted				
Low Energy					Trauma Flashbacks				
Loneliness					Mood Swings				
Excessive Worry					Obsessive Thoughts				
Excessive Guilt					Disorganized				
Panic Attacks					Grief				
Anorexia					Headaches				
Bulimia					Suicidal Thoughts				
Weight Loss					Past Suicide Attempts				
Weight Gain					Alcohol Use				
Feeling Panicky					Drug Use				
Phobias					Cutting				
Feeling Anxious					Self-Harm				
Problems at School					Problems at Home				

List any additional concerns or symptoms:

What stressors or life changes have you experienced recently?

What brings you to therapy now?

Have you seen a therapist in the past?			
Year	**Problem/Reason for attending therapy**	**Therapist/Clinic**	**How Long?**

Your family growing up:			
Relationship	**First Name**	**Is the relationship (Negative, Contentious or Supportive)?**	**Mental Health History**

Who lives with you now?			
Relationship	**First Name**	**Is the relationship (Negative, Contentious or Supportive**	**Mental Health History**

Where are you currently living?

Family:

Family Concerns, Please check off any concerns that your family is currently facing

Symptom	None	Mild	Mod	Severe	Symptom	None	Mild	Mod	Severe
Fighting					Lack of honesty				
Feeling Distant					Financial Problems				
Disagreeing about friends					Feeling Unsafe				
Loss of fun					Drug Use				
Alcohol Use					Abuse/Neglect				

Describe any other family concerns that you may have:

Are your parents married, divorced, separated?

If they are divorced or separated who do you primarily live with?

Do you have any siblings? If yes what is your relationship like with them?

Education:

What grade are you in?

What is your favorite subject?

How many hours per week do you spend doing your homework?

To what extent are you satisfied with your grades in school?

Briefly describe what you like and dislike about going to school:

Home/ Personal Life:

How do you spend personal time? (hobbies, sports, clubs, groups, family activities, etc.)

Are you happy with the amount of friends that you have? Y_____ N_____

How often do you spend time with your friends outside of school?

Do you open up about your feelings, or do you tend to keep them all to yourself?

Who can you talk with about personal feelings or private matters?

Are you satisfied with your romantic life? Are you in a romantic relationship (girlfriend/boyfriend)?

Briefly describe what you like and dislike about your relationships:

Health:

Accident or Illness	**Date**	**Treatment received (if known)**	**Accident or Illness**	**Date**	**Treatment Received (if known)**
Recent Surgery			Head Injury		
Seizures			Thyroid Problems		
Drug/Alcohol abuse treatment			Neurological Disorder		
Chronic Pain			Headaches		
Diabetes			Hormone Problems		
Infertility			Miscarriages		

If any explanation is needed please list here:

List any other chronic health problems you may have:

List any prescription or over-the-counter medications you may take, along with the purpose of the medicine:

Medication	Dose	Purpose	Prescribing doctor

Who is your primary pediatrician/physician?

When was your last physical?

Do you exercise? What do you do? How often?

Are you concerned about your physical health?

How many hours do you sleep in an average night?

How many meals a day do you eat a day?

Have you ever had troubles with eating or weight loss/gain?

Substance Use:

Substance	**Current Use (past 6 months)**				**Past Use**			
	Yes	No	Frequency	Amount	Yes	No	Frequency	Amount
Alcohol								
Tobacco								
Marijuana								
Crack/Cocaine								
Heroin								
Percoset								
Oxycotin								
Vicodin								
Other Opiates								
Ecstasy								
Steroids								
Methamphetamines								
Synthetics								
Other								

List Other: _____

Accomplishments / Additional Information:

List your personal strengths:

What are your expectations of therapy?

How long do you expect to be here?

What are some things you want to talk about?