Adult Biography

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

Client Information

Name: ____ **Date:** ____________

Gender: [ ] Male [ ] Female [ ] Other: _____________________ **Pronouns:** ____________

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**

Your childhood			
[ ] Happy Childhood	[ ] Neglected	[ ] Moved Frequently	[ ] Few Friends
[ ] Weight Problems	[ ] Sexually Abused	[ ] Physically Abused	[ ] Emotionally Abused
[ ] Popular	[ ] Parents Divorced	[ ] Family Fights	[ ] Poor Grades
[ ] Conflict with Teachers	[ ] Drug or Alcohol Use	[ ] Sexual Problems	[ ] Good Grades
[ ] Depressed	[ ] Anxious	[ ] "Spoiled"	[ ] Not Allowed to Grow Up
[ ] Attention Problems	[ ] Anger Problems	[ ] Mom Absent	[ ] Dad Absent

Any additional childhood experiences or symptoms:

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

Where are you currently living?

Relationship History:

How many times have you been married?

How old were you at the time of your marriage(s)?

Briefly describe any problems in your current or past marriages or cohabitation relationships:

Education and Occupations:

Are you currently [ ] Working [ ] In school [ ] Both [ ] Neither

Highest level of education so far?

What is (or was) your major or favorite subject?

How many hours per week are you working?

In what field do you usually work?

What is your current or most recent job title?

Briefly describe what you like and dislike about your employment or school:

Home/ Personal Life:

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

How many contacts do you have each month with friends outside of work or school?

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

Are you satisfied with your romantic life?

Briefly describe what you like and dislike about your current romantic and friendship lives:

Health:

Please Check All That Apply

[ ] Recent Surgery	[ ] Head Injury
[ ] Seizures	[ ] Thyroid Problems
[ ] Drug/Alcohol Abuse Treatment	[ ] Neurological Disorder
[ ] Chronic Pain	[ ] Headaches
[ ] Diabetes	[ ] Hormone Problems
[ ] Infertility	[ ] Miscarriages

List any other chronic health problems you may have:

How many hours do you sleep in an average night?

How many drinks (containing alcohol) do you consume in an average week?

Which recreational drugs have you used in the last year?

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

Medication	Dose	Purpose	Prescribing doctor

Do you exercise? How? How often?

Do you use tobacco? How much?

Who is your primary physician? (Include phone number if known)

When was your last physical?

Are you concerned about your physical health? If yes, explain.

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 and important accomplishments:

What are your expectations of therapy?

How long do you expect to be here?

What are some things you want to talk about?

List any additional information that it might be important for your therapist to know:

What is your name? (Who filled in this form?)