Psychology Resources
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:

____
____
____
____

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?
______	______________	______________	______________
______	______________	______________	______________

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?
______	___________	______________	__________	____________
______	___________	______________	__________	____________

3. Describe any significant physical health problems/concerns:

____
____
____

(cont.)

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D. Relationships. Please describe the following:

1. List the people who live at home:

Name:	Age:	Relationship to patient:	Occupation:

2. Relationship between adults in the home:

____

____

____

____

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

____

____

____

____

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

____

____

____

____

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):

____

____

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

Names	Good parts of relationship	Bad parts of relationship

(cont.)

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

____
____
____
____

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:

□ Does not do homework	□ Excessive time to complete assignments	□ Distracted
□ Poor handwriting	□ Forget assignments	□ Test Anxiety
□ Does not remain seated	□ Starts but does not finish homework	□ Excessive talking
□ Noncompliant in class	□ Incomplete classroom work	□ Careless errors
□ Fails to check homework	□ Poor attention in class	□ 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.)

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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:

____

____

____

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: ____

   ____

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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