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Adolescent Background History:

Name: ____

Date of Birth: ________________________ Initial Appointment Date: _____________________

Left- or Right-Handed: __________________ Language(s) Spoken: ________________________

Grade: _____________________________ School: ___________________________________

Who completed this form?

____

Social History:

Where were you born? _________________________________

Please list all of the different cities/states in which you have lived since birth:	Ages or Years

Parents Names: ___________________________ ___________________________

Is your mother living? Yes No Is your father living? Yes No

If no, please explain when and how they passed away.

Are your parents still married to each other or together? Yes No

If not, please explain when they divorced/separated: ________________________________

Are your parents re-married? Yes No

Mother's Job: _________________________Father's Job: __________________________

If your parents were divorced how often do/did you see your parent who does/did not live with you?

How many sisters do you have? _____ How many brothers do you have? ____

Please list your sisters/brothers names, ages, current jobs and any learning problems.

Name	Age	Current Job	Any learning problems?
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No

Has how you were treated and raised as a child had more of a positive or negative effect on your personality? Positive Negative

If you circled negative, please explain:

Are there any traumatic events that have influenced your life?

Were you ever abused or mistreated? Yes No

If yes, please circle all that apply: _____ None

Sexual Abuse	Physical Abuse	Emotional Abuse	Neglect

Was the Department of Children and Families (DCF) ever involved with your family as a child?
Yes No

Has anyone in **your family** been diagnosed with any of the following? _____ None

Depression	Learning Disability	Obsessive Compulsive Disorder	Bipolar Disorder
Schizophrenia	Intellectual Disability (MR)	Substance Abuse/Alcoholism	Autism
Anxiety	Conduct Disorder	Personality Disorder	ADHD/ADD
Other			

<u>Current Family History:</u>

Have you ever been married? Yes No How many times? ____

Spouse Name	Date Married	Date Separated/Divorced

Who do you currently live with?

____

Do you currently have a boyfriend/girlfriend? Yes No
How long?

____
Describe any common problems in your romantic relationships:

Do you have difficulty making friends? Yes No
Do you have difficulty keeping friends? Yes No

Number of close friends: _______
How often do you spend time with
them?____
____

Describe any common problems in your relationships with friends:

Currently, what do you do for fun?
Do you have any children? Yes No

Name of child	Age	Current Job	Any learning problems?
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No

Custody Status: Full Time:_________50/50 Split:___________ Weekends:___________
No Contact:______________ Other:____________________
Has DCF been involved with your current family? Yes No
If yes, explain:

Developmental History:

Circle any of the following that were problems with **your** birth or delivery. _____ Within normal limits

Premature	Low Birth Weight	Gestational Diabetes	Jaundice
C-Section	Mom drank alcohol	Mom smoked	Mom used illegal drugs

Circle below whether you met your developmental milestones on time:

Talking? Yes No Walking? Yes No Toilet Training? Yes No
Did you have any speech difficulties? Never As a child Currently
Did you ever receive speech therapy? Yes No If so, when? _______________

Have you ever received occupational therapy? Yes No If so, when? _______________

Have you ever received physical therapy? Yes No If so, when? _______________

Medical History:

Place an "X" in the appropriate range if you have suffered from any of the following: _____None

Medical Disorder	Birth to age 12	As an adolescent/adult
Chronic Ear Infections		
Cancer		
HIV/AIDS		
Heart Attack		
Concussion		
Seizure/Epilepsy		
Broken Bones		
Chronic Stomach Problems		
Asthma		
Meningitis		
Multiple Sclerosis		
Thyroid Condition		
High Blood Pressure		
Diabetes		
Other		

Have you ever had surgery? Yes No If Yes, explain:

Any visual difficulties? Yes No Do you wear glasses or contacts? Yes No
Any hearing difficulties? Yes No Do you wear a hearing aid? Yes No

Circle any mental health disorder in which **you** have been diagnosed: _____ None

Depression	Learning Disability	Obsessive Compulsive Disorder	Bipolar Disorder
Schizophrenia	Intellectual Disability (MR)	Substance Abuse/Alcoholism	Autism
Anxiety	Conduct Disorder	Personality Disorder	ADHD/ADD
Other			

Please list any prescription medications that you currently use: _____ None

Medication	For What?	Doctor Who Prescribed?

Mental Health History:

Circle any of the following which have been an issue for you over the past year:

Getting to work/school on time	Fidgeting	Eating too little/too much	Getting along with people
Nervousness/Anxiety	Sad most of the day	Suicidal thoughts	Paying attention
Poor communication	Restlessness	Emotional control	Anger management
Self-esteem	Not thinking before I act	Self-injury	Organization
Easily distracted	Talk too much	Risky/Illegal behavior	Obsessions
Irritability	Loss of interest in normally enjoyable activities	Phobia with ___________________________	
Excessive spending	Sleep too much/too little	Vomit after eating	Hallucinations
Bizarre thinking	Hoarding	Unproductive rituals	Forgetfulness
Few close friends	Procrastination	Test Anxiety	Panic attacks

Have you been to counseling before? Yes No If so, when?___________________
Who was the therapist? What were you treated for?

Have you ever received inpatient hospitalization for a mental health issue? Yes No
If yes, explain each placement.

Have you ever attempted suicide? Yes No How many times? _________
Please explain each attempt:

Drug and Alcohol Use:

Please circle all substances you have used in the past: _____None
Alcohol, PCP (angel dust), marijuana, amphetamines (speed), cocaine, crack cocaine, hallucinogens (acid, mushrooms), ecstasy, methamphetamine (meth), opium, heroin, sleeping pills, pain killers
Please include last use for any items circled
____
____
____

What substances do you currently use? How often?

Have you ever been treated for drug or alcohol abuse? Yes No
If so, when and where?

Have you ever lost a job or relationship because of substance abuse? Yes No
If so, when and what happened?

Have you ever been in legal trouble for drug or alcohol abuse? Yes No
If so, when and what happened?

Legal History:

Have you ever been in trouble with the law? Yes No

If so, when and what happened?

Offense	Date	Length of jail time, probation, or fine

Educational History:

Did you attend Preschool? Yes No If so, where?__________________________

Please list all of the schools you have attended.

School	City, State	Ages or Years or Grades Attended

Did you graduate high school? Yes No When did you graduate? ________________

If you have not graduated, when do you expect to? ____________________________

Did you graduate with a standard diploma? Yes No

If you did not graduate high school, did you get a GED? Yes No

Do you intend to go to college? Yes No

Have you attended any college? Yes No Major _________________________

Did you graduate from college? Yes No Degree ________________________

If you attended college but did not finish, please explain.

Did you have an Individualized Education Program (IEP)/504 Plan? Yes No

Were you in special education/Exceptional Student Education (ESE) in school? Yes No

If so, which grade were you in when you began special education? ________________

Circle any disability that you were placed in ESE/special education for:

Reading learning disability	Math learning disability	Writing learning disability	Speech impaired
Hearing impaired	Visually impaired	Emotional disturbance	Mental retardation
Autism/Asperger's	Traumatic Brain Injury	Medical impairment	Other

What types of accommodations or help with school do/did you receive (mark all that apply)?

Extended time on tests	Tests taken in a quiet space	Tests taken in small group	Additional time to complete assignments
Intensive Reading	Intensive Mathematics	Social-Communication Classroom	Behavior Unit Classroom
Intensive English/Language Arts	Speech or Language Therapy	Occupational Therapy	Physical Therapy
Shortened Assignments	Subjects taught below grade level curriculum	Exempt from state-wide standardized tests	Functioning Living Skills Classroom

Did you ever have to repeat a grade? Yes No If so, what grade(s)?___________
Did you ever get in trouble at school? Yes No If so, when did it start?___________
Did you ever get detentions? Yes No Did you ever get suspended? Yes No
What types of behaviors did you get in trouble for at school?
Did you ever get expelled from school? Yes No What grade were you in?___________
If so, why were you expelled?

Please list any after school activities that you participated in (e.g., clubs, sports)

Daily Living:

Can you drive a car?	Yes	No
Do you have a driver's license?	Yes	No
Do you own/lease your own car?	Yes	No
Can you do your own laundry?	Yes	No
Can you calculate change?	Yes	No
Can you do your own grocery shopping?	Yes	No
Can you cook for yourself or your family?	Yes	No
Can you bathe and dress yourself without help?	Yes	No

Financial History:

Have you ever filed for bankruptcy? Yes No
If yes, please explain.

Describe your current debt: ____

You are financially dependent on (circle all that apply): Self Spouse Parents/Family SSI/SSID Other: __________________

Do you own your home or pay rent?
Are you able to pay your bills on time? Yes No

If No, explain why?

Do you have a checking account? Yes No

Describe any difficulties that you have maintaining your finances:

Job History:

In order, please list your job titles, where you worked, how long and why you left? _____None

Job Title	Business Name	How long?	Why did you leave?

Can you complete a job application without help? Yes No

Circle any of the following that have made it difficult for you to find or keep a job?

Reading	Math	Writing	Medical	Alcohol/Drugs	Mental Health	Legal

At work, do you have difficulty getting along with supervisors? Yes No

At work, do you have difficulty getting along with co-workers? Yes No

At work, do you have difficulty getting along with customers? Yes No

Have you ever been fired from a job? Yes No

If yes, please explain.

What strengths do you offer a job?

What are your weaknesses on the job?

What types of jobs would you like to do in the future?

What types of jobs would you not like to do in the future?