Anchor Psychology, Inc.
1975 Hamilton Ave.
Suites 11 & 37
San Jose, CA 95125

main: 408.340.5875
anchorpsychology.net

BIOGRAPHICAL INFORMATION (MINOR & YOUNG ADULT)

Please fill out this biographical background form for yourself as completely as possible. It will help me in our work together. Information is confidential as outlined in the Outpatient Services Contract. You might decide to discuss some of the information requested in this form in person rather than providing a written response. If you do not desire to answer any question, merely write, "**Do not care to answer**." If you are pressed for time, please complete as much information as possible.

Date: _____

IDENTIFYING INFORMATION

Name of Parent Completing this Form: _____

Name of Other Parent: _____

Name of Minor: _____

Date of Birth: _____ Age: _____

Gender: ☐ Male ☐ Female ☐ Other: _____

Parents are: ☐ Married ☐ Separated ☐ Divorced ☐ Other: _____

Minor currently lives with: _____

Visitation Schedule if Divorced/Separated: _____

Address: _____
_____
_____

Phone #: _____

E-Mail: _____

Anchor Psychology, Inc.
1975 Hamilton Ave.
Suites 11 & 37
San Jose, CA 95125

main: 408.340.5875
anchorpsychology.net

REASONS FOR SEEKING THERAPY

1. Presenting Problem (Be as specific as you can: When did it start? How is it affecting your daily functioning?): _____

_____

_____

_____

2. Estimate the severity of above problem: ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

3. What have you tried so far to correct/manage the problem(s)? _____

_____

_____

_____

4. Please list all previous counseling treatment.

Dates	# of Sessions	Therapist	Problem Treated & Diagnoses	Reason for Termination

5. Have you ever been evaluated by a psychiatrist or tested by a psychologist? Please list:

Dates	# of Sessions	Therapist	Problem Treated & Diagnoses	Reason for Termination

6. Have you ever sought counseling for your personal/marital life? Please list:

Dates	# of Sessions	Therapist	Problem Treated & Diagnoses	Reason for Termination

7. Have you or your child ever been hospitalized for emotional reasons? If YES, please explain. _____

_____

_____

_____

8. Please list any developmental, emotional, learning or psychiatric diagnosis (along with the date when the diagnosis was given) that your child/teen has received in the past: _____

_____

_____

_____

9. Has your child/teen ever seen an occupational or physical therapist? If so, please include diagnoses.

_____

_____

_____

10. Does your child/teen suffer from any recurring pains and/or medical problems? If so, please describe.

_____

_____

_____

11. Please list any additional stressful/traumatic circumstances that have affected or are currently affecting your child/teen:

Relational Problems: _____
Financial Problems: _____
Legal Problems: _____
Educational Problems: _____
Housing Problems: _____
Physical Abuse: _____
Sexual Abuse: _____
Domestic Violence: _____
Medical Trauma/Problems: _____
Other: _____

12. How have you handled them up to now? _____

_____

_____

_____

13. Which of the aforementioned would you like help with? _____

_____

_____

_____

14. What areas of your child's/teen's life do you feel are affected by these problems? Please describe.

Home: _____
School: _____
Health: _____
Relationships: _____
Family Life: _____
Other: _____

15. Describe any changes in your child's/teen's:

Energy: _____
Sleep: _____
Appetite: _____
Other: _____

16. Has your child/teen ever had thoughts of harming another person? ____ YES ____ NO

If YES, describe when and how. _____
_____
_____

17. Has your child/teen ever had thoughts of harming his/herself? ____ YES ____ NO

If YES, describe when and how. _____
_____
_____

CURRENT LIVING SITUATION

18. Please list all the people you currently live with:

Name	Relationship	Age	Occupation	Employer/School

19. PARENTS' PRESENT and/or PAST MARRIAGE(S)

Number of mother's previous marriages? _____
Name of Mother's Partner(s): _____
Dates/Years: _____
Nature of Relationship (i.e., friendly, distant, physically/emotionally abusive, loving, hostile): _____
_____
_____
_____

Number of father's previous marriages? _____
Name of Father's Partner(s): _____
Dates/Years: _____
Nature of Relationship (i.e., friendly, distant, physically/emotionally abusive, loving, hostile): _____
_____
_____
_____

20. Siblings (If passed, provide age/year and cause of death).:

Name	Age	Nature of Relationship (i.e., friendly, distant, physically/emotionally abusive, loving, hostile):

MEDICAL HISTORY

21. Medical Doctor(s) (name and phone): _____
_____

22. When was your child's/teen's last medical exam? _____
Doctor's Name: _____
Reason seen: _____
_____
_____

23. Past/Present Medical Care (major medical problems, surgeries, accidents, falls, head injuries, illness):

_____

_____

_____

24. List medications your child/teen is currently taking or took in the past.

Medication	Dosage	Dates Taken	Reason

25. Family medical history (Describe any illness that runs in the family – i.e., cancer, epilepsy, etc.): ___

_____

_____

_____

ALCOHOL/DRUG USE HISTORY

26. Your child's/teen's current alcohol and drug consumption (please check appropriate answers):

Usual Alcohol Consumption: ☐ None ☐ 1-2 drinks per sitting ☐ 3-4 drinks per sitting ☐ 5+ drinks per sitting

Frequency of Alcohol Consumption: ☐ Never ☐ 1 time/month ☐ 1 time/week ☐ 2-3 times/week ☐ Daily

Frequency of Intoxication: ☐ Never ☐ 1 time/month ☐ 1 time/week ☐ 2-3 times/week ☐ Daily

Frequency of Drug Use: ☐ Never ☐ 1 time/month ☐ 1 time/week ☐ 2-3 times/week ☐ Daily

27. Have you or anyone else had concern about your child's/teen's drinking or drug use? If YES, who and why? _____

_____

_____

_____

28. Is your child/teen currently in a relationship with someone who uses alcohol/drugs? If YES, who and what do they use? _____

_____

_____

_____

29. Does or did anyone in your child's/teen's family of origin (or significant person in her/his life) abuse alcohol and/or drugs? If YES, please state the relationship, drug, and pattern of use. _____

_____

_____

_____

FAMILY HISTORY

30. Is there history of the following? If YES, please describe who and helpful details.

Suicide	□ NO	□ YES	
Depression	□ NO	□ YES	
Psychiatric Problems	□ NO	□ YES	
Violence	□ NO	□ YES	
Alcohol/Drug Use	□ NO	□ YES	

31. Please list anyone that has died who was close to your child/teen and its impact on her/him. _____

_____

_____

_____

32. If you are divorced or separated, what was your child's/teen's age at the time? Describe its impact on her/him: _____

_____

_____

_____

CLINICAL & RISK ASSESSMENT

33. Areas of Clinical Concern: Please rate your level of concern regarding the following conditions:

	No Concern	Some Concern	Very Concerned	Elaborate if needed.
Depression				
Anxiety				
Impulsivity				
Hyperactivity				
Defiance				
Lack of Empathy				
Anger Control				
Suicide Risk				
Self-Mutilation				
Other Self-Harm				
Danger to Others				
Sexual Aggression				
Runaway				
Delinquency				

34. Usage of Technology: Please state your perception of your child's/teen's level of usage of the following:

	Low	Average	Excessive
Social Media			
Video Games			
Texting			
General Internet Use			
Television			

PERSONAL AND PROFESSIONAL INFORMATION

35. School Details: Provide the grade level your child/teen is in, as well as the name of the school they are attending. _____
_____
_____
_____

36. Friendships, Community, Social Support and Spirituality: Describe quality, frequency, activities, etc.

37. Are you (or your child/teen) involved in any current or pending civil or criminal litigations, lawsuits, and/or divorce or custody disputes? If yes, please explain.

38. What are your main worries and fears with respect to your child/teen?

42. What do you want for your child's/teen's future?

43. Please add any other information you would like me to know about your child/teen and your family in terms of the past or a present situation.