Katherine Latter Counseling, PC —*seeing you through the seasons of your life*

FAMILY BACKGROUND INFORMATION FORM

ADOLESCENT (AGES 12-17) | PARENT/GUARDIAN SECTION

Please note that the information is important for your child's care. Please fill out forms as completely as possible and have them ready before your first counseling session. This form is confidential and will be securely maintained as part of your child's clinical file.

CLIENT INFORMATION

Adolescent's Full Name:			Preferred Name:
Date of Birth:	Age:	Gender: ☐ Male ☐ Female ☐ Other:	
Preferred Pronoun: ☐ He ☐ She ☐ Other:			
Race/Ethnic Origin:		Religious Preference:	
School:			Grade:

PARENT/GUARDIAN INFORMATION

Parent/Guardian Full Name:			Preferred Name:
Date of Birth:	Age:	Gender: ☐ Male ☐ Female ☐ Other:	
Preferred Pronoun: ☐ He ☐ She ☐ Other:			
Occupations(s):			
Place of Employment:			
Highest Grade of Education:		Degree/Diploma(s):	
How did you hear about us?			
Person completing form:		Relationship:	
CONTACT INFORMATION			
Address:			
City:		State:	Zip Code:
PHONE	Home Phone:		☐ OK to leave message
	Cell Phone:		☐ OK to leave message
	Work Phone:		☐ OK to leave message
EMERGENCY CONTACT INFORMATION			
Name:		Relationship:	Phone:

CURRENT HOUSEHOLD AND FAMILY INFORMATION

(if additional space is needed, please list on back of form)

Name	Relationship (parent, sibling, etc.)	Age	Sex	Type (bio, step, etc.)	Living With You
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N

CURRENT REASON FOR SEEKING COUNSELING FOR YOUR ADOLESCENT

Briefly describe the problem that has brought you in for counseling: _____

_____

How long have these issues been troubling you? _____

Are there situations that cause the issues to get worse? ☐ Yes ☐ No — IF YES, please describe:

_____

Are there situations that cause the symptoms to improve/subside? ☐ Yes ☐ No — IF YES, please describe:

_____

What would you like to see happen as a result of counseling? _____

_____

What is most concerning right now? _____

_____

Are both parents in agreement with bringing the adolescent in for counseling? ☐ Yes ☐ No

Please describe any recent changes for your family (births, deaths, moves, accidents, crisis, etc.):

_____

_____

How does the adolescent feel about counseling at this time? _____

_____

What family members are likely willing to participate in your adolescent's counseling?

_____

COUNSELING / MEDICAL HISTORY

Has your adolescent previously seen a counselor? ☐ Yes ☐ No

IF YES: Where and with whom? _____

Approximate dates of counseling: _____

For what reason did your adolescent go to counseling? _____

Does your adolescent have a previous mental health diagnosis? _____

What did you find **most helpful** in therapy? _____

_____

What did you find **least helpful** in therapy? _____

_____

Has your adolescent used psychiatric services? ☐ Yes ☐ No

IF YES— Who did they see? _____

IF YES—Was it helpful? ☐ Yes ☐ No

Has your adolescent ever taken medication for a mental health concern? ☐ Yes ☐ No

IF YES, please list below the name of medication, dates taken and its effectiveness

Name of Medication	Dates Taken	Prescribing Physician	Was it helpful ?
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N

Does your adolescent have other medical concerns or previous hospitalizations or surgeries? ☐ Yes ☐ No

IF YES—please describe: _____

_____

Adolescent's current physician: _____ Phone: _____

Hospital: _____

Address: _____

Date of last medical exam: _____

Has your adolescent ever had a head injury? ☐ Yes ☐ No — IF YES, please explain:

_____

Please list all **current** medical conditions/concerns (e.g., high blood pressure, headaches, dizziness, etc.):

_____

_____

Please list all **past** medical conditions/concerns (e.g., high blood pressure, headaches, dizziness, etc.):

_____

_____

Does your adolescent have any allergies? ☐ Yes ☐ No — IF YES, please list: _____

_____

_____

Is your adolescent **currently** taking any medications? ☐ Yes ☐ No

IF YES, please list the name of medication, dosage, prescribing physician and purpose:

Current Medication	Dosage	Prescribing Physician	Reason for Taking

CHEMICAL USE

Do you have any concerns with your adolescent using alcohol, drugs, tobacco, or caffeine? ☐ Yes ☐ No

IF YES—please explain your concern: _____

INTERNET/ELECTRONIC COMMUNICATIONS USE

Is your adolescent on social media? ☐ Yes ☐ No ☐ Unsure

IF YES—please share electronic communication (Facebook, Twitter, Snapchat, Instagram, etc.) that they use:

Do you have access to their electronic communication/social media? ☐ Yes ☐ No

IF NO—please explain: _____

Do you have any concerns with your adolescent using the internet or electronic communication ☐ Yes ☐ No such as Facebook, Snapchat, Twitter, texting etc?

IF YES—please explain your concern: _____

PEER RELATIONS

Are your parents happy with your adolescent's friends/peer relationships? ☐ Yes ☐ No

IF NO—please explain: _____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family, adolescent, at present, or have had a significant effect upon you or your adolescent in the past.

ADOLESCENT'S DEVELOPMENT

Were there any complications with the pregnancy or delivery of your adolescent? ☐ Yes ☐ No

IF YES—please describe: _____

Did your adolescent have health problems at birth? ☐ Yes ☐ No

IF YES—please describe: _____

Did your adolescent experience any developmental delays (e.g. toilet training, walking, talking)? ☐ Yes ☐ No ☐ Not sure

IF YES—please describe: _____

Did your adolescent have any unusual behaviors or problems prior to age 3? ☐ Yes ☐ No ☐ Not sure

IF YES—please describe: _____

Has your adolescent experienced emotional, physical, or sexual abuse? ☐ Yes ☐ No ☐ Not sure

IF YES—which types of abuse? ☐ Emotional ☐ Verbal ☐ Physical ☐ Sexual ☐ Not sure

IF YES—please describe: _____

Are you aware of any birth trauma your adolescent experienced from age 0-3? ☐ Yes ☐ No

IF YES—please describe: _____

To the best of your ability indicate what you know about your adolescent from when they were growing inside of their mother's womb to when they turned 3 years old. Please indicate all that apply.

- ☐ Pregnancy difficulties / abnormalities
- ☐ Walking/gross motor problems
- ☐ Alcohol/illegal drugs during pregnancy
- ☐ Drugs used by mother or father at time of conception
- ☐ Overly social/friendly
- ☐ Poor attachment to parents/caregivers
- ☐ Problems sleeping as a baby
- ☐ Did not meet developmental milestones
- ☐ Medication during pregnancy
- ☐ Difficulties during pregnancy
- ☐ Speech/language problem
- ☐ Hand coordination/fine motor problems
- ☐ Exposure to lead
- ☐ Problems eating as a baby
- ☐ Excessive fears
- ☐ Difficult to comfort
- ☐ Eating non foods
- ☐ Away from parents for a long time
- ☐ Overweight at birth
- ☐ Premature birth
- ☐ Underweight at birth

Please explain any of the above: _____

FAMILY HISTORY

Did **you** (parent/guardian) experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable:

Have **you** (parent/guardian) experienced any abuse in your adult life (physical, verbal, emotional, or sexual)?

Please indicate all that apply to the **adolescent's** life so far.

- ☐ Alcohol or drug abuse (indicate by whom and when): _____
- ☐ Sexual or physical abuse (indicate by whom and when): _____
- ☐ Known family history of physical or sexual abuse: _____
- ☐ Abortion (if so when): _____

☐ Basic needs not met (food, shelter, clothes)	☐ Unemployment	☐ Natural disaster
☐ Death in the family	☐ Frequent moves	☐ Purging
☐ Violence in home	☐ Emotional abuse	☐ Crime Victim
☐ Parental illness	☐ Body Image Issues	☐ Living in constant fear
☐ Parental/Guardian separation	☐ Strong feelings of guilt or shame	☐ Weight issues
☐ Parental Divorce	☐ Financial stress	☐ Extreme Dieting

Please explain any of the above: _____

Have any of the adolescent's family members ever had any type of counseling before? ☐ Yes ☐ No

IF YES—please explain: _____

Have any of the adolescent's family members ever seriously considered, attempted or completed suicide? ☐ Yes ☐ No

IF YES—please explain: _____

PARENT'S MARITAL STATUS *(this section refers to the biological parents relationship)*

☐ SINGLE ☐ MARRIED (legally) ☐ DOMESTIC PARTNERSHIP/CIVIL UNION ☐ DATING

☐ COHABITATING ☐ DIVORCE-IN-PROGRESS ☐ SEPARATED ☐ WIDOWED

☐ OTHER: _____

Length of marriage/relationship: _____

If divorced/separated, how old was your child at time of divorce/separation? _____

If divorced/separated, how much time does your child spend with each parent? Mother _____% Father _____%

Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent.

Biological Father's Name: _____ Birth Date: _____ Age: _____

If deceased, how old was the child when he passed away? _____

Race/Ethnic Origin: _____ Religious Preference: _____

Total years of education completed: _____ Occupation: _____

Place of employment: _____

Military experience? ☐ Yes ☐ No IF YES—Branch: _____

Combat experience? ☐ Yes ☐ No IF YES—where/when: _____

CURRENT STATUS

☐ SINGLE ☐ MARRIED (legally) ☐ DIVORCED ☐ COHABITATING ☐ DIVORCE-IN-PROGRESS

☐ SEPARATED ☐ WIDOWED ☐ OTHER: _____

Assessment of current relationship with bio-mother if applicable: ☐ Poor ☐ Fair ☐ Good

Please explain: _____

Biological Mother's Name: _____ Birth Date: _____ Age: _____

If deceased, how old was the child when she passed away? _____

Race/Ethnic Origin: _____ Religious Preference: _____

Total years of education completed: _____ Occupation: _____

Place of employment: _____

Military experience? ☐ Yes ☐ No IF YES—Branch: _____

Combat experience? ☐ Yes ☐ No IF YES—where/when: _____

CURRENT STATUS

☐ SINGLE ☐ MARRIED (legally) ☐ DIVORCED ☐ COHABITATING ☐ DIVORCE-IN-PROGRESS

☐ SEPARATED ☐ WIDOWED ☐ OTHER: _____

Assessment of current relationship with bio-father if applicable: ☐ Poor ☐ Fair ☐ Good

Please explain: _____

FAMILY CONCERNS *(please check any concerns below that your family is currently experiencing)*

- ☐ Fighting
- ☐ Feeling distant
- ☐ Loss of fun
- ☐ Lack of honesty
- ☐ Physical fights
- ☐ Education problems
- ☐ Financial problems
- ☐ Death of a family member
- ☐ Disagreeing with relatives
- ☐ Disagreeing about friends
- ☐ Alcohol use
- ☐ Drug use
- ☐ Infidelity (couple)
- ☐ Divorce/separation
- ☐ Issues regarding remarriage
- ☐ Birth of sibling
- ☐ Abuse/neglect
- ☐ Inadequate housing
- ☐ Feeling unsafe
- ☐ Job change or job dissatisfaction
- ☐ Birth of a child
- ☐ Inadequate health insurance

Other: _____

_____

YOUR ADOLESCENT'S STRENGTHS

In your opinion, what situations or activities do you see your child thrive? _____

_____

_____

What are some of your child's personal qualities? _____

_____

_____

Who and what are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your son or daughter's life? Please described:

_____

_____

INDIVIDUAL CONCERNS YOU NOTICE REGARDING YOUR SON OR DAUGHTER

Please identify your current concerns and their severity

SYMPTOM	NONE	MILD	MOD	SEVERE	SYMPTOM	NONE	MILD	MOD	SEVERE
Acting without thinking					Body image issues				
Alcohol use					Bulimia				
Anger issues					Compulsive eating				
Angry mood					Crying/tearful				
Anorexia					Cutting				
Appetite changes					Day wetting				
Argumentative					Delinquency				
Arrests					Dieting				
Avoidance of responsibility					Difficulty concentrating				
Bed wetting					Difficulty sleeping				
Binging/purging					Disorganized				
Blames others					Drug use				

SYMPTOM	NONE	MILD	MOD	SEVERE	SYMPTOM	NONE	MILD	MOD	SEVERE
Elevated mood					Indecisiveness				
Exaggerated sense of worth					Internet relationship(s)				
Excessive worry					Irritability				
Excessive exercise					Lack of confidence				
Exposure to traumatic event					Loneliness				
Extreme shyness					Lots of energy				
Fatigue/easily tired					Low energy				
Feeling panicky					Low self-worth				
Fire setting					Lying				
Frequent conflicts					Mood swings				
Frequent physical complaints					Muscle tension				
Grief					Nausea/indigestion				
Hair pulling					Nightmares				
Hallucinations					Not interested in things				
Hard to remember things					Interrupting others				
Harming others					Panic attacks				
Hear or see things other do not					Paranoid thoughts				
Helplessness					Past suicide attempts				
Hopelessness					Phobias				
Hurting animals					Poor decisions				
Hurting self					Pornography				
Hyperactivity					Pre-occupation with sex				
Impulsivity					Prescription drug abuse				

Is there anything else you would like to share? _____

_____

_____

_____

_____

_____

_____

Special Confidentiality Notice for Parents

Your child has the right to private, confidential communication with the doctor, therapist, and treatment team providing his or her care. This means that some of the issues that they discuss will stay between them, and that we will not disclose that information to anyone, including you, unless we have been given permission by your child to do so. We need your child to be open and honest with us in order to understand and treat the full range of issues your child is dealing with, and they may be too scared, angry, or ashamed right now to share those issues with you. We also recognize it is very important for you to know what your child is going through in order to do your job as a parent, which is why we will always encourage your child to be honest with you. We will encourage, prepare and support your child so that they feel safe enough to share those issues with you.

According to Washington State law, American Counseling Association (ACA) and the federal patient privacy law known as HIPAA, your child will need to give his/her consent for us to disclose:

- All Mental Health records for children age 13 or older.
- All information concerning pregnancy, sexual activity, STD's, and drug/alcohol use or abuse, regardless of the child's age.
- Any information that your child's provider believes, if released, could cause harm to your child or to someone else, or that would significantly harm the treatment relationship with your child.

You should know that this confidentiality has limits. If there is any threat to your child's life, we have the duty to inform you and help to create a plan for safety.

In addition, there are situations that we are mandated to report and cannot keep confidential. Those situations include: threats against another person, physical or sexual abuse, neglect, and pregnant women who report using drugs.

Finally, we recognize how challenging it can be for a parent to raise a child, especially when the child may be experiencing some mental health issues. We know how badly you might want to know everything your child has kept a secret from you, too. We want to be your partner in supporting your child's physical and mental wellbeing, and even when we can't discuss certain details about your child with you, we will always be there for you: guiding you and giving your child the best advice possible to protect him/her and encourage healthy decisions, including being open and honest with you.

My signature below confirms that I have done my absolute best to answer the following questions honestly and completely.

PRINTED NAME

SIGNATURE

DATE