BALDWIN COUNSELING

2832 S. Lynnhaven Rd. STE. 102 Virginia Beach, VA 23452
Office: (757) 340-0275 Fax: (757) 340-0276

Patient Information and Social History

Adolescent (13-17)

Name: ____ Today's Date: ___________
Last First MI

Address: ____

Home Phone: (___)_______________ Parent Work/Cell: (___)_____________

SSN: _______________ DOB:____________ Present Age: _____

Father's Name: ____________________ Father's DOB: ___________ Father's SSN: ______________

Father's Home Phone: (___)_________Father's Cell: (__)_________Father's Work: (___)___________

Father's Address: ____

Father's Email Address: ____

Mother's Name: _____________________ Mother's DOB: _________ Mother's SSN: _____________

Mother's Home Phone: (___)________ Mother's Cell: (__)________ Mother's Work: (___)_________

Mother's Address: ____

Mother's Email Address: ____

Guardian *(if applicable)*: __________________________ Guardian Home Phone:(___)_______________

Guardian Cell Phone:(___)_________________ Guardian Work Phone: (___)____________________

Guardian Address: ____

Guardian's Email Address: ____

Type of Guardian *(DHS, Grandparent, ect.)*: ____

Legal

Is parent involved in litigation/court: ____No ____Yes

If yes, answer the following questions; if no, proceed to the next section

Primary Custodial Parent: ______________________ Guardian *ad litem*: ______________________

Signature: ____________________ Date: ___________ Client ID: ____________

Guardian *ad litem* Phone: (___)________________ Guardian *ad litem* Fax: (___)________________

Guardian *ad litem* Address: ____

Consent to release / release information must be signed

Foster Care Guardian *(If applicable)*: ____

List any court ordered parental restrictions to information *(i.e. restraining orders or no legal custody)*:

____

Identify visitation schedule of adolescent: ____

Pending court dates: _________date _____time _______________location _________________reason

Financial

Please note: The party who signs the payment agreement is accountable for all charges incurred on the adolescent's account.

The party signing the payment agreement will receive all reminder calls.

Responsible party for payment/insurance: ____

Relationship to client: ______________ SSN: ________________ DOB: ______________

Employer: ____________________ Email: ____

Address: ____

Presenting Problem

Please briefly describe the reason for seeking care:

____

____

____

____

____

Signature: _____________________ Date: ____________ Client ID: _____________

BALDWIN COUNSELING
2832 S. Lynnhaven Rd. STE. 102 Virginia Beach, VA 23452
Office: (757) 340-0275 Fax: (757) 340-0276

Adolescent Medical History

If currently under physician's care a primary care physician release form must be signed

Primary Care Physician: ____________________________________ Phone: ____________________

Address: ____

Current health concerns: ____

Prescribed medications: ____

Over the counter medications: ____

Current psychiatric care: ______No _______Yes If yes, please answer following questions

_____Psychiatrist _____Therapist _____Rehabilitation _____Inpatient Services

Provider name:____________________________ Provider Phone number: __________________

Provider address: ____

Reason for seeking care:____

If currently receiving care consent to exchange information must be signed

Previous psychiatric care: ______No _______Yes If yes, please answer following questions

_____Psychiatrist _____Therapist _____Rehabilitation _____In Patient Services

Provider name:____________________________ Provider Phone number: __________________

Provider address: ____

Reason for seeking care:____

Is the adolescent sexually active: ____No ____Yes If yes, age of first sexual activity: ____________

Concerns regarding Anorexia ____No ____Yes If yes, describe: ________________________________

____

Concerns regarding Bulimia: ____No ____Yes If yes, describe: ________________________________

____

Signature: ______________________ Date: ____________ Client ID: _____________

Drug abuse: ____No ____Yes if yes, describe: ____

____

Alcohol abuse: ____No ____Yes if yes, describe: ____

____

Injuries or accidents *(particularly blows to the head)*:____

Describe adolescent's health: ____

Describe any medical conditions: ____

Allergies: ____

Daily Schedule

Sleep Pattern: ____Normal ____Very Sound ____Restless ____Nightmares Hours of Sleep: ______

Bedtime: _____ Time of Waking: ______ Resists Sleep?: ____No ____Yes

Security Items: ____No ____Yes If yes, please describe___________________________________

General appetite and eating habits: ____

Supervision arrangements *(if applicable)*: ____

Educational Information

Current School: ___________________________ City: ___________________ Grade:____________

Teacher's Name: __________________________

Academic progress: ____

Your expectations: ____

Signature: ______________________ Date: ____________ Client ID: _____________

BALDWIN COUNSELING

2832 S. Lynnhaven Rd. STE. 102 Virginia Beach, VA 23452
Office: (757) 340-0275 Fax: (757) 340-0276

Schools Attended	Grade Level	Performance
______________________________	________________________	___________________________
______________________________	________________________	___________________________
______________________________	________________________	___________________________
______________________________	________________________	___________________________

Unpleasant school experiences: ____

Grades retained and why: ____

Most difficult subject: ________________ Best subject: _______________ IEP: ___No ___Yes

504: ____No ____Yes *If yes, please provide copies* 504/IEP Triennial review date: ______________

Resists attending school: ____No ____Yes Reads other than assigned books: ____No ____Yes

Truancy concerns: ____No ____Yes if yes, describe:____

In school suspension: ____No ____Yes if yes, describe:____

Out of school suspension: ___No ___Yes if yes, describe: ______________________________________

Educational testing: ___No ___Yes If yes, provide copies _____School Testing _____Private Testing

Where does he/she study: _________________ Parents help with studying: ____No _____Yes

Adolescent's plans after high school graduation (if known): _______________________________________

____

Other comments on school:

____

____

Signature: ______________________ Date: ____________ Client ID: _____________

BALDWIN COUNSELING
2832 S. Lynnhaven Rd. STE. 102 Virginia Beach, VA 23452
Office: (757) 340-0275 Fax: (757) 340-0276

Adolescent Criminal History

Does the adolescent have any pending criminal charges: ____No ____Yes If yes, describe: ______

____

Charge	Adjudicated Yes/No	Date

Family Relationships

List all people living in the household (*if parents separated/divorced use second section for other parent)*

Name	Age	Grade Level	Relationship to Client

Other households that the adolescent lives in:

Name	Age	Grade Level	Relationship to Client

Signature: ______________________ Date: ____________ Client ID: _____________

2832 S. Lynnhaven Rd. STE. 102 Virginia Beach, VA 23452
Office: (757) 340-0275 Fax: (757) 340-0276

___________________________ ________ ________________ _____________________

___________________________ ________ ________________ _____________________

___________________________ ________ ________________ _____________________

Describe the father-child relationship: ____

____

Describe the emotional attachment to the father: ____

____

Describe the mother-child relationship:____

____

Describe the emotional attachment to the mother: ____

____

Describe relationship with significant caregiver: ____

____

Describe the emotional attachment with significant caregiver: __________________________________

____

Activities with father: ____

Activities with mother: ____

Family activities (Mother/Father/ Both) *circle one* *Complete next question if separated/divorced*

____

If separated/divorced Family activities (Mother/Father)*circle one*:

____

Mother's discipline type: ___________________________________ Consistent: _____No ______Yes

Father's discipline type: _____________________________________ Consistent: _____No ______Yes

Other guardian/caretaker's discipline type: _______________________ Consistent: _____No _____Yes

Signature: _____________________ Date: ____________ Client ID: _____________

BALDWIN COUNSELING
2832 S. Lynnhaven Rd. STE. 102 Virginia Beach, VA 23452
Office: (757) 340-0275 Fax: (757) 340-0276

Who administers discipline: ____

Adolescent's responsibilities: ____

Personality of adolescent: ____anxious ____depressed ____extroverted ____introverted

____imaginative ____loner ____social ____sensitive ____happy ____unhappy

Activity level of adolescent: ____active ____aggressive ____difficulty remembering ____impulsive

____organized ____loses things easily ____prefers quiet play

Martial Situation

____Married ____Living together/not married ____Separated ____Divorced

____Widowed ____Never married If married, number of years in present marriage: _____

Describe your present marriage: ____poor ____tolerate each other ____relatively happy ____happy

Additional comments: ____

If remarried since the birth of client, how old was (s)he: when you divorced: ______ remarried:_______

If separated/divorced, who has primary physical custody: ____

Please note: Step-parents do not have access to medical information unless a release is signed

Stepfather or significant other's name: _________________ Role:___________________________________

Stepmother or significant other's name: ________________Role:___________________________________

What are the legal custody arrangements: ____

Visitation Schedule: ____

Court ordered restrictions:____

If adolescent is in care of Department of Human Services (DHS) please complete the following:

Release must be signed for collaboration

Legal guardian:___________________________________ Title/Role: ________________________

Address: ____

Signature: ______________________ Date: ____________ Client ID: ______________

BALDWIN COUNSELING

2832 S. Lynnhaven Rd. STE. 102 Virginia Beach, VA 23452
Office: (757) 340-0275 Fax: (757) 340-0276

Contact information: ____

Foster care parent(s) name: ____

Foster care parents(s) address: ____

Foster care parent(s) phone: _____________(home) ______________(cell) _____________(work)

Length of time in foster care: ____________ Length of time in current foster home: ______________

Therapeutic foster home: _____no _____yes if yes, identify reason:____________________________

Identify service providers/team members:

Name	Phone	Reason for services
________________________	__________________	____________________________________
________________________	__________________	____________________________________
________________________	__________________	____________________________________
________________________	__________________	____________________________________
________________________	__________________	____________________________________
________________________	__________________	____________________________________
________________________	__________________	____________________________________

Parental History

Biological Father:

Name: ___________________________ DOB: ____________ SSN: _____________________

Birth Place: ____________________ Highest Level of Education Completed: ___________________

Describe any difficulties in school: ____

Place of employment: ___________________________ Occupation: ___________________________

Work hours: ____

Drug abuse: ____none ____current ____past if current/past marked, describe: __________________

Signature: _____________________ Date: ____________ Client ID: _____________

Alcohol abuse: ___none ____current ____past if current/past marked, describe: ___________________

Criminal history: ____

Other marriages: ____

Past physical or psychological concerns: ____

Current physical or psychological concerns: ____

Biological Mother:

Name: _____________________________ DOB: _____________ SSN: ______________________

Birth Place: ____________________ Highest Level of Education Completed: _____________________

Describe any difficulties in school: ____

Place of employment: _____________________________ Occupation: _____________________________

Work hours: ____

Drug abuse: ____none ____current ____past if current/past marked, describe: ___________________

Alcohol abuse: ___none ____current ____past if current/past marked, describe: ___________________

Criminal history: ____

Other marriages: ____

Past physical or psychological concerns: ____

Current physical or psychological concerns: ____

Reviewed By: ____ Date:____________________