

Young Adult Information Form

ATTN: Unless there is a serious risk of injury to you or someone else, the information on this form is confidential. It will not be discussed with your parents without your consent.

Your name: _____ Today's date: _____ Your age: _____

Your address: _____ Phone #: _____

Health

How tall are you? _____ How much do you weigh? _____

What physical or medical problems do you have now, or have you had in the past? _____

Family

Birth parents' names: _____ and _____

Address: _____ Ph #: _____

Present parents'/guardians' names: _____ and _____

Address: _____ Ph#: _____

How would you describe you parents' relationship? _____

What kinds of problems are you having with:

Parents/stepparents/guardians?

Parents' live-in friends or boyfriends/girlfriends?

Brothers or sisters (or stepbrothers or stepsisters)?

School

Which school do you go to? _____ Grade level/year: _____

How are your grades? _____

Problems in school? _____

Work

Do you work? _____ If so, where? _____

Problems there? _____

Friends

Who are your close friends (names and ages)?

Do you have a serious one-on-one relationship now? _____

Previous counseling

1. With whom? _____ When? _____

For what? _____

With what results? _____

Concerns

Would you like information or answers on: Sex Alcohol Drugs Birth control Relationships

Other _____

Is religion important to you and/or your family? Yes No If yes, in what ways? _____

What worries or upsets you? _____

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What makes you happy?

Why do you think you are here? Please tell me in your own words.

What would you like to see happen or change because of this counseling?

What would you like me to let your parents know?

What else is important for me to know?

What would you like me to ask you about?

Signed: _____ Date: _____

