Coral Compagnoni, LMFT

Licensed Marriage and Family Therapist #84799

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Biographical Information Form - Minor

Please fill out this form as fully and openly as possible. All information is held in **strictest confidence** within legal limits. If certain questions do not apply to you, cross them out or write "N/A."

Today's Date: ______________________________

Name: ____ Age: ______ Date of Birth: ____________
Gender: Male / Female / Trans Male / Trans Female / Non-binary / Other / Decline to Answer
Ethnicity: ___________________________________
Grade: __________________________ School:____

Mother's Name: ____ Phone: _________________________
Father's Name: ____ Phone: _________________________
Parent's Relationship Status:

- ___ **Married, if so, for how long: _________**
- ___ **Never married, in committed relationship, if so, for how long: ______**
- ___ **Never married, not currently in committed relationship, if so where you ever in a committed relationships, and when did that end: ________________**
- ___ **Separated, if so, for how long: ____________________**
- ___ **Divorced, if so, for how long: __________**
- ___ **Other: ____**

Minor's Primary Address:

____

Street & Number City State Zip

Minor's Secondary Address:

____

Street & Number

Others living with Minor	Age	Sex	Relationship		Others living with you	Age	Sex	Relationship
1)					3)			
2)					4)			

Person to call in case of an emergency: _________________________ Relationship to Minor: ____________
Emergency Contact Phone Number(s):

____

How did you hear about me (if referred, by whom?):

____

If referred, is it ok with you for me to thank your referral? Yes / No ____________
Client initial

Presenting Issue

What is/are your main reason(s) for seeking therapy & what is the motivation to seek therapy <u>at this time</u>?

____

____

____

____

When did this (these) problem(s) begin? ____

____

Counseling And Medical History

Are you receiving counseling/therapy services at present? Yes_____ No_____ If yes, please briefly describe:____

____

Name of therapist: ________________________ **Phone Number** ____________________

Have you received counseling/therapy in the past? Yes_____ No_____

Name of therapist: ________________________ Dates Seen: ________________________

Address: ______________________________Phone Number: ____________________

Type of therapy: ____________________ Focus of Therapy: ______________________

Was the therapy helpful? Please explain: ______________________________________

Has a mood or behavior altering drug/medication ever been prescribed for you? If so, what and when?

____

Have you ever been hospitalized? If so, when and for what? Please explain: ____________________

____

Primary Care Physician: ____

Address: ______________________________ Phone: ________________________

When was your most recent complete physical exam?______________________________

Results of physical exam: ____

List any physical/medical problems you are having at present: (e.g., headaches, dizziness, upset stomach, etc.):

____

____

Have you ever been bitten by a tick? No / Yes **Anyone in your family bitten by a tick?** No / Yes

Sleep Habits: On average, how many hours of sleep do you get daily? _____ What time do you go to bed? _____

Any sleep difficulties? No / Yes If yes, describe ______________________________

Eating Habits: Do you now, or have you ever, engaged in binge eating, purging, restricting food, compulsive exercising, or other compulsive eating behavior? If so, please explain: ________________________

____

Have you gained/lost over ten pounds in the past year? Yes / No If yes, was it intentional? Yes / No

Describe your appetite for the past 2-weeks: Poor appetite____ Average appetite____ Large appetite____

Screen Time: How many hours per day do you spend on electronic devices? ____________________

How many hours per day are spent gaming? ________ How many hours per day on social media? __________________