Erin E. Siemers Ph.D. LLC
2008 W. 120th Ave
Bldg A, Suite 9
Westminster, CO 80234
erin@siemersphd.com
www.siemersphd.com

Young Adult Information Form

Full Name: _____ Date of Birth: _____

Former Names: _____ Age:_____ Sex: Male/ Female

Marital Status: ___ Never Married ___ Married ___ Divorced ___ Separated ___ Widowed

Handedness: Right Left Ambidextrous

I presently am living: ___Alone ___With others (please specify): _____

_____
_____

Whose idea was it for you to come here today?_____
_____

Briefly state the main concerns for which you are presently seeking help:
_____
_____
_____

How long have you had these concerns: _____
_____
_____

What things have you tried to deal with these concerns?: _____
_____
_____

<u>Occupational History:</u>

Are you currently employed? ___Yes ___No How long have you worked in this position_____

Job/ Type of Work: _____

Please list some examples of previous jobs you have held: _____

_____

Academic History:

Highest level of schooling you have completed to date: _____

Skipped Grades: Yes/ No Which ones?_____ Reason: _____
Repeated Grades: Yes/ No Which ones?_____ Reason: _____

Have you ever received any special education, enrichment or resource services? Yes/ No
(describe): _____
_____
_____
_____

If you currently are a student:
Name of school/ college: _____ Grade/ Level: _____
Major area of study: _____
Present grades: _____
_____

Describe any academic problems you are having: _____
_____
_____

Have you ever received psychological or cognitive testing before? Yes/ No When?_____

- **If yes, please have a copy of the results mailed to Dr. Siemers**

Are you currently receiving any special education, enrichment or resource services? Yes/ No
(Describe): _____

_____

- **If you have a current Individual Education Plan (IEP), please enclose a copy or have it sent by the school to Dr. Siemers**

Medical History:

Present illnesses for which you are being treated: _____
_____
_____

Are you taking any medications on an ongoing basis: Yes/ No

Name of Medication	Dosage	Name of prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any difficulties following your doctors' advice or treatment: _____
_____

Please indicate if you have had any history of the following medical problems:

	Circle One	Ages	Describe
Allergies	Yes/ No		
Appetite/ Eating Problems	Yes/ No		
Asthma	Yes/ No		
Cancer	Yes/ No		
Clumsiness/ Poor Motor Skills	Yes/ No		
Chronic Ear Infections	Yes/ No		
Diabetes	Yes/ No		
Headaches	Yes/ No		
Hearing/ Ear Problems	Yes/ No		
Head injury	Yes/ No		
Nightmares	Yes/ No		
Persistent Fevers	Yes/ No		
Physical Disabilities	Yes/ No		
Seizures	Yes/ No		
Sleep Apnea/ Snoring	Yes/ No		
Surgeries	Yes/ No		
Tics/ Twitching	Yes/ No		
Vision/ Eye Problems	Yes/ No		
Alcohol Use/ Abuse	Yes/ No		
Illicit Drug Use/ Abuse	Yes/ No		
Risky Behaviors	Yes/ No		

Please add any additional information about the above concerns: _____
_____
_____

Hospitalizations: Yes/ No (describe): _____
_____
_____

Other issues or concerns regarding your health: _____
_____
_____
_____

Please list counselors, psychotherapists, psychologists, or psychiatrists you have seen:

Age	Provider Name	Service (testing, treatment, medication)	Helpful
____	_____	_____	Yes/ No
____	_____	_____	Yes/ No
____	_____	_____	Yes/ No
____	_____	_____	Yes/ No

History of any psychiatric hospitalizations? Yes/ No (describe): _____
_____

History of taking medications for attention, mood or behavior? Yes/ No (describe): _____
_____

Family History:

Highest grade completed by mother: _____ Highest grade completed by father: _____
Mother's occupation: _____ Father's occupation: _____

Parent's marital status: __Married __Divorced __Separated __Deceased ___Never Married

If your parents are married, how long have they been married?_____
If separated or divorced, your age at the time: _____ Dates of any remarriages: _____

Please list the names of siblings for biological, half, and step-siblings:

Name	Age	Living at home with you
_____	_____	Yes/ No
_____	_____	Yes/ No
_____	_____	Yes/ No
_____	_____	Yes/ No
_____	_____	Yes/ No
_____	_____	Yes/ No
_____	_____	Yes/ No
_____	_____	Yes/ No

Family history of medical problems: Yes/ No (describe) _____
_____
_____

Family history of attention or learning problems: Yes/ No (describe)_____
_____
_____

Family history of behavioral, mood or psychological problems: Yes/ No (describe)_____
_____
_____

Additional Information:

Please list some of your personal strengths and talents: _____
_____
_____
_____

Please check any of the following stressors that apply to you or your family and describe:

- ☐ Relocations: _____
- ☐ Job changes: _____
- ☐ Deaths: _____
- ☐ Illnesses: _____
- ☐ Marital Problems: _____
- ☐ Someone significant moving away: _____
- ☐ Experiencing a traumatic event: _____
- ☐ Witnessing a traumatic event: _____
- ☐ Physical or sexual abuse or neglect: _____
- ☐ Division of Family Services (DFS) involvement: _____
- ☐ Legal issues: _____
- ☐ Other: _____
- ☐ Other: _____

Please write any additional remarks you may wish to make below.

_____
_____
_____
_____
_____
_____

Thank you for taking the time to complete this information.