safe connections
Where violence ends and healthy relationships begin

ADOLESCENT DATA FORM

Client Case #: _____ **Date of Assessment:** _____

First Name: _____ **Preferred Name:** _____

Last Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Safe to send mail? ___Yes ___No **Alternate address:** _____

Teen's Phone: **(_____)-**_____ Safe to leave message? Yes No

Email Address: _____ Safe to email? Yes No

Parent/Guardian #1 First Name: _____ **Last Name:** _____

Phone: **(_____)-**_____ Safe to leave message? Yes No

Email _____ Safe to email? Yes No

Parent/Guardian #2 First Name: _____ **Last Name:** _____

Phone: **(_____)-**_____ Safe to leave message? Yes No

Have you received services at Safe Connections before? ___Yes ___No

Did you use another name? ___Yes ___No If so, Name: _____

The mission of Safe Connections is to reduce the impact and incidence of relationship violence and sexual assault through education, crisis intervention, counseling and support services. *We do not discriminate on the basis of race, color, sex, citizenship status, national origin, ancestry*, gender, sexual orientation, gender identity, gender expression, age, religion, creed, physical or mental disability, marital status, veteran status, political affiliation, or any other factor protected by law.

I request that Safe Connections consider my application for service.

Signed_____ **Date**_____

Updated 6/2019

INFORMATION ABOUT YOU

The information on this page is requested so that this organization may demonstrate its compliance with the requirements of its funding agencies including the United Way. Choosing not to respond to some of the questions on this page will not affect your application for services.

Birth Date: _____/_____/_____ **Age**: _____

Race /Ethnic Background:

- ☐ African American/ Black
- ☐ Asian/ South Asian
- ☐ Bi-Racial /Multi-Racial
- ☐ White/ Caucasian
- ☐ Hispanic/Latina or Latino
- ☐ American Indian/ Alaska Native
- ☐ Middle Eastern/ Arab
- ☐ Native Hawaiian/ Pacific Islander
- ☐ _____

Sexual Orientation:

- ☐ Asexual
- ☐ Bisexual
- ☐ Straight/Heterosexual
- ☐ Lesbian/Gay
- ☐ Pansexual
- ☐ Queer
- ☐ Prefer not to Disclose
- ☐ _____

Gender:

- ☐ Woman/ Girl
- ☐ Trans Identified
- ☐ Man/ Boy
- ☐ Non-Binary/Genderqueer
- ☐ _____

Pronouns: _____
(Ex: She/Her/Hers)

Relationship Status: Are you currently (as of today)

- ☐ In a relationship
  Partner(s) Gender or Pronouns:_____
- ☐ Not currently in a relationship
- ☐ Unsure of relationship status
- ☐ Other

Do you have any special needs we can accommodate?

_____

Current Employment Status:

- ☐ Unemployed (with work history)
- ☐ Unemployed (with no work history)
- ☐ Employed

If employed, what is your occupation?

_____

Are you currently in school? ___Yes ___No

If no, Last grade completed: _____

If yes, Current grade level? _____

What School? _____

Parent's Relationship Status (as of today)

- ☐ Together
- ☐ Separate households
- ☐ Deceased: ____Mom _____Dad

Who do you live with?

- ☐ Parent(s): _____
- ☐ Foster Parent(s)
- ☐ Other Relative
- ☐ Roommate
- ☐ Live Alone
- ☐ Residential Facility: _____
- ☐ Other: _____

Any cultural concerns?

_____

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What is your current household income?

- ☐ $0-$9,999
- ☐ $10,000-$14,999
- ☐ $15,000-$19,999
- ☐ Unknown
- ☐ $20,000-$29,999
- ☐ $30,000-$49,999
- ☐ $50,000-$99,999
- ☐ More than $100,000

Number in household: _____

Referred to Safe Connections from:

- ☐ Friends/Family
- ☐ Other Counseling Agency
- ☐ Private Therapist
- ☐ Telephone Directory
- ☐ Schools: Project HART
- ☐ Schools: Colleges
- ☐ Schools
- ☐ Lawyer
- ☐ Courts
- ☐ Police
- ☐ Doctor
- ☐ Hospital/E.R.
- ☐ Employer
- ☐ EAP
- ☐ Religious Community
- ☐ Safe Connections Helpline
- ☐ Other Hotline
- ☐ Billboards
- ☐ Shelter
- ☐ Substance Abuse Program
- ☐ Media/Public Service Announcement
- ☐ Own Previous Agency Contact
- ☐ Other

Are you mandated to receive services? ____Yes____ No

If yes, by whom?

Check one and fill in name: ____ Children's Division – Case manager's Name: _____

____ Probation/Parole – Officer's Name: _____

Reason mandated:_____

CURRENT STRESSORS: ***(Check all that apply)***

- _____ Loss/Lack of support (family or friends)
- _____ Current safety issues
- _____ Relationship issues
- _____ Financial problems
- _____ Homelessness
- _____ Employment issues
- _____ Legal problems
- _____Other: _____

COUNSELING/PSYCHIATRIC HISTORY

Have you ever been in the care of a psychiatrist? ___Yes ___No

If yes:

Who_____

When_____

Have you ever been hospitalized for a psychiatric disorder? ___Yes ___No

If yes:

How many times? _____

Most recent _____

Where _____

When _____

Reason _____

Do you take prescription medications (for medical and/or psychiatric reasons)? ___Yes ___No

If yes:

Please list current medications _____

How long have you taken these medications? _____

Do you take it: _____ As prescribed

_____ Less than prescribed

_____ More than prescribed

Have you ever had suicidal thoughts? ___Yes ___No

Have you ever attempted suicide? ___Yes ___No

If yes:

How many times? _____

Most recent _____

When _____

Method _____

Are you currently suicidal? ___Yes ___No

If yes:

Do you have a plan? Explain: _____

Do you have the means available? _____

Is there anyone you could turn to for support? _____

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Have you ever received any kind of counseling/therapy? ___Yes ___No

If yes:

At what age did you first seek therapy? _____

How many prior counselors/therapists have you seen?_____

Name of most recent Counselor/Therapist and Facility_____

When?_____ How long? _____Years _____Months

What was the motivation for the **above** counseling or therapy? *(check all that apply)*

_____ Domestic Violence
_____ Economic Problems
_____ Family Problems
_____ Required by Probation /Parole
_____ Relationship Issues
_____ Personal Growth
_____ Sexual/Gender Identity
_____ Sexual Abuse
_____ Emotional Abuse
_____ Substance Abuse
_____ Legal Problems
_____ Psychological Problems
_____ Other personal difficulties

What kind of counseling /therapy services did you receive? *(check all that apply)*

_____ Individual Counseling /Therapy
_____ Couples Counseling
_____ Peer Support Group
_____ Family Counseling

Have you *ABUSED* alcohol and/or drugs in the past? ___Yes ___No

If yes:

What have you used? _____

Within the ***past 2 weeks,*** have you ***used*** any alcohol and/or drugs? ____Yes_____No

If yes, what have you used? _____

Have you ever been in a detox or rehab program? _____Yes _____No

If yes, number of times: _____

Name of program/center: _____

Do you drink/use drugs to be accepted by partner? _____Yes _____No

Do you drink/use drugs to relieve stress at home? _____Yes _____No