



CHILD AND ADOLESCENT INFORMATION

CLIENT INFORMATION

Child's Name _____ Birthdate _____
 Age _____ Sex _____ Race _____ Religious Affiliation _____

PARENT/GUARDIAN CONTACT INFORMATION

Parent/Legal Guardian's Name _____
 Relationship to Child _____ Social Security Number _____
 Home Address _____
 City _____ State _____ Zip _____
 Home Phone Number _____ Okay to leave a message? Yes No
 Work Phone Number _____ Okay to leave a message? Yes No
 Cell Phone Number _____ Okay to leave a message? Yes No
 Emergency Contact Person _____
 Relationship to you _____
 Contact's Phone Number _____

PARENT/HOUSEHOLD INFORMATION

Parent's Name _____ Age _____ Education _____
 Current Type of Employment _____
 Parent's Name _____ Age _____ Education _____
 Current Type of Employment _____
 Are these child's parents: Married Separated Divorced Never Married

 Are there step-parents involved with the child? Yes No
 If yes, what are their names and relationship to the child.
 Step-parent's Name Married to Child's... Date of Marriage

Please list the child's siblings

<u>Name</u>	<u>Age</u>	<u>Lives with Child</u>
_____	_____	Yes No
_____	_____	Yes No
_____	_____	Yes No
_____	_____	Yes No

Are there other individuals who also live in the household? If yes, please list.

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____

SCHOOL INFORMATION

Child's School _____ Grade _____
 School Address _____
 School Phone Number _____
 School Contact Person _____
 Relationship to Child _____

LEGAL INFORMATION

Does your child or family have any legal involvement? Yes No
 Does your child or family have any DFCS involvement? Yes No
 If so, please explain.

MENTAL HEALTH HISTORY

What concerns do you have about your child? When did they start?

Please circle any of the following areas of concern for your child, either past or present?

Alcohol/Drug Abuse	Medical Issues	Depressed Mood	Body Image
Homicidal Thoughts	Aggression	Legal Involvement	Physical Complaints
Distractibility	Bedwetting	Problems Finishing Work	Obsessions/Compulsions
Decreased Attention	Soiling	Suicidal Thoughts/Acts	Binge Eating
Poor Concentration	Helplessness	Hallucinations/Delusions	Lying
Sleeping Problems	Shyness	Bullying/Teasing	Fighting
Motor/Vocal Tics	Impulse Control Problems	Confused Often	Stealing
Hyperactivity	Low Self-Esteem	Nightmares	Fire Setting
Oppositional	Food Issues	Family Problems	Trauma
Irritability	Cruelty to Animals	Excessive Worrying	Anger Management
Sexual Abuse	Runaway	Separation Anxiety	School Problems
Physical Abuse/ Neglect	Witnessing Domestic Violence	Self-Harming Behavior	Parental Separation/Divorce
Developmental Delays	Social Skills	Perfectionism	Disorganization

Has your child/family ever received psychological services in the past? Yes No

<u>Date</u>	<u>Nature of Problem</u>	<u>Therapist</u>	<u>Benefit From Therapy?</u>
_____	_____	_____	Yes No
_____	_____	_____	Yes No

Has your child been previously diagnosed with a psychological disorder? Yes No

Diagnoses given:

Please describe any trauma experienced by the child: (i.e. car accident, death of a loved one/pet, natural disaster, physical/sexual abuse)

<u>Description</u>	<u>Age/Year</u>
_____	_____
_____	_____

Are there any psychological or psychiatric problems in the family such as ADHD, Bipolar Disorder, Schizophrenia, Depression or Anxiety?

Relationship to Child

Problem/Diagnosis

DEVELOPMENTAL HISTORY

Pregnancy and Delivery

Length of Pregnancy: Full Term Premature at _____ weeks Late

Type of delivery _____

Mother's age at child's birth _____ Child's Birth Weight _____

Did any of the following conditions occur during the pregnancy/delivery? (Please Circle)

Toxemia	Alcohol Use	Frequent Nausea	Serious illness or injury	Post-Partum Depression
Illegal Drugs Use	Forceps used during delivery	Cigarette Use	Took prescription medications	Mild _____ Moderate _____ Severe _____

Infancy

Did any of the following conditions affect your child during delivery/infancy? (Please Circle)

Born drug positive	Injured during delivery	Heart distress
Cord around neck	Trouble breathing	Needed Oxygen
Congenital Defect	Hospitalized more than 1 week	Required medications
Jaundiced	Seizures	Infections

As an infant, which words best described your child: (Please Circle)

Difficulty sleeping	Difficulty Feeding	Cranky/unpleasant mood
Affectionate	Cheerful	Active
Difficult to engage	Social	Withdrew from people
Overactive	Tantrums	Difficulty with change

How old was your child when he/she was able to:

Crawl _____

Use words _____

Walk _____

Potty trained _____

MEDICAL HISTORY

Child's Physician _____ Phone Number _____

Date of Last Medical Visit _____

Any Medical Problems _____

Current Medications:

Medication	Dosage	Reason for Use	Physician
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Please circle the appropriate response for your child

Medical Issue	Never	Past	Present
Asthma	Never	Past	Present
Allergies	Never	Past	Present
Chronic Illness *(specify_____)	Never	Past	Present
Seizure Disorder	Never	Past	Present
Frequent Headaches/Migraines	Never	Past	Present
Heart Problems	Never	Past	Present
High Fevers	Never	Past	Present
Broken Bones	Never	Past	Present
Stitches	Never	Past	Present
Surgery (specify_____)	Never	Past	Present
Hospitalization	Never	Past	Present
Speech/Language Problems	Never	Past	Present
Motor Problems (i.e.coordination, clumsy, fine or gross)	Never	Past	Present
Ear Infections	Never	Past	Present
Developmental Delay	Never	Past	Present
Hearing Problems	Never	Past	Present
Vision Problems	Never	Past	Present
Handwriting Problems	Never	Past	Present
Eating Problems	Never	Past	Present
Diabetes	Never	Past	Present
Stroke	Never	Past	Present
Transplants	Never	Past	Present
Head Injury	Never	Past	Present

Please provide information about chronic health issue and/or ongoing medical treatment.

Do any of the child's relatives have medical problems?

Yes No

Relationship to Child

Medical Condition

REFERRAL INFORMATION

Referred by: _____

Do we have your permission to thank your referral source?

Yes No