

CHILD/ADOLESCENT INFORMATION FORM

Child Name: _____ Age: _____ DOB: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Gender: Male Female Who referred you here? _____
Name of Parents/Legal Guardians: _____
Home Phone: () _____ OK to leave message? Yes No
Work Phone: () _____ OK to leave message? Yes No

WHO MAY WE CONTACT IN CASE OF EMERGENCY? _____

Daytime Phone: () _____ Evening Phone: () _____
Name of adolescent's work place (if applicable): _____

Legal Information

Was this child adopted? Yes No
Has this child ever been a ward of the court with DHS (formerly SCF) guardianship? Yes No
Has this child ever been the subject of a custody case? Yes No
Does this child have any legal offenses on record or pending in the courts? Yes No

If yes to any of the above, please describe the situation and the name of the DHS/OYA caseworker and/or the child's attorney's name:

CHILD'S PREVIOUS MENTAL HEALTH TREATMENT

Type of Treatment	No	Yes	Start/End dates	Provider name/primary reason for treatment
Counseling or Psychiatric Care				
Drug/Alcohol Treatment				
Medication for mental health problem				
Self-help/support group				

CHILD'S PRESENTING PROBLEMS/CONCERNS

Describe the problem that brought you here today:

What do you hope to gain from therapy?

Therapist Notes:

Child/Adolescent Information Form

Please check behaviors and symptoms that occur to you more often than you would like:

(Note: Trauma/abuse symptoms and school problems are listed on later pages.)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Aggression/fighting | <input type="checkbox"/> Distractibility | <input type="checkbox"/> Inattention | <input type="checkbox"/> Sexual acting out |
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Angry outbursts | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Somatic complaints |
| <input type="checkbox"/> Arguments/conflicts | <input type="checkbox"/> Elevated mood | <input type="checkbox"/> Low self esteem | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Avoiding people | <input type="checkbox"/> Fire setting | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Thoughts disorganized |
| <input type="checkbox"/> Bedwetting/bowel probs. | <input type="checkbox"/> Frequent illness | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Computer addiction | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Phobias/fears | <input type="checkbox"/> Withdrawn/isolated |
| <input type="checkbox"/> Delinquency/runaway | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Poor judgment | <input type="checkbox"/> Worrying |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hyperactivity/
Impulsivity | <input type="checkbox"/> Obsessive thoughts | |
| <input type="checkbox"/> Developmental delays | | <input type="checkbox"/> Oppositional defiance | |
| <input type="checkbox"/> Other _____ | | | |
-

Briefly describe how the above checked symptoms impair your ability to function effectively:

Has he/she ever had thoughts or made statement of wanting to hurt themselves or seriously hurt someone else? Yes No. If yes, please describe the situation:

Has he/she ever purposely hurt themselves or another? Yes No. If yes, please describe the situation:

Please describe your child's strengths, skills, interests and talents:

What would you like me to know about spiritual, religious, cultural, ethnic or other values or traditions in this child's life?

Therapist Notes:

FAMILY & DEVELOPMENTAL HISTORY

Relationship	Name	Age	Deceased Y - N	Quality of Relationship	Family mental health problems?	Who?
Mother					Depression	
Father					Anxiety	
Stepmother					Sexual abuse	
Stepfather					Attention deficit	
Spouse/partner					Alcohol abuse	
Children					Drug abuse	
					Schizophrenia	
					Manic-depression	
					Imprisonment	
Siblings					Suicide	
					Eating disorders	
					Panic attacks	
					Obsessive/ compulsive	

Parental Marital Information:

- Parents legally married
- Parents have been separated
- Parents divorced
- Mother remarried: Number of times _____
- Father remarried: Number of times _____

If parents are separated or divorced, what is the current child custody and visitation arrangement?

Is there anything happening NOW in your current living situation or in your family that is especially stressful for the child or you?

If any, please check the areas where your child had difficulties in early childhood:

- Feeding
- Talking
- Crawling/walking
- Separation anxiety
- Sleeping
- Riding tricycle
- Riding bicycle
- Dressing self
- Toilet training
- Tying shoes

Please describe the difficulties checked above:

<p>Therapist Notes:</p>

Child/Adolescent Information Form

Please briefly describe how this child gets along with other children:

Did the child's biological mother use any tobacco, medication, street drugs, or alcohol during the pregnancy of this child? Yes No. If yes, please describe what substances were used, as well as how much and how often the use occurred:

Please check if this child has suffered any of the following types of trauma:

- | | | |
|--|--|---|
| <input type="checkbox"/> Neglect | <input type="checkbox"/> Emotional abuse | <input type="checkbox"/> Physical abuse |
| <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Loss of a loved one | <input type="checkbox"/> Natural disaster |
| <input type="checkbox"/> Teenage pregnancy | <input type="checkbox"/> Parental substance abuse | <input type="checkbox"/> Crime victim |
| <input type="checkbox"/> Violence in the home | <input type="checkbox"/> Parents separated or divorced | <input type="checkbox"/> Financial problems |
| <input type="checkbox"/> Parental illness | <input type="checkbox"/> Homelessness | <input type="checkbox"/> Lived in a foster home |
| <input type="checkbox"/> Multiple family moves | <input type="checkbox"/> Other _____ | |

Please comment on any of the above checked items (including age of child at time of trauma and the details of the traumatic event):

CHILD/ADOLESCENT CHEMICAL USE HISTORY *(Please complete if child is 12 or older)*

Substance Type	Current Use (within the last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
PCP/LSD								
Heroin/opiates								
Methamphetamines								
Inhalants								
Other								

Has your child had withdrawal symptoms when trying to stop using any substances? Yes No. If yes, please describe the situation:

Have any substances created a problem for your child at school, work or home? Yes No. If yes, please describe the situation:

SCHOOL INFORMATION

Current School: _____ Primary Teacher Name: _____

Current grade/placement: _____ How long at this school: _____

Main contact person(s) at school: _____

Does this child have an after school care provider? Yes No. If yes, give name(s):

What does this child’s teacher(s) say about him/her?

Other schools attended:

Headstart/preschool: _____

Elementary: _____

Middle School: _____

High School: _____

Has this child ever repeated/skipped a grade? Yes No. If yes, which one(s)? _____

Has this child ever received Special Education services? Yes No. If yes, please describe the services received and the reason for services:

Has this child exhibited any of the following difficulties at school?

- | | | |
|--|--|--|
| <input type="checkbox"/> Fighting | <input type="checkbox"/> Suspension | <input type="checkbox"/> Poor grades |
| <input type="checkbox"/> Lack of friends | <input type="checkbox"/> Learning problems | <input type="checkbox"/> Detention |
| <input type="checkbox"/> Incomplete homework | <input type="checkbox"/> Smoking/alcohol/drugs | <input type="checkbox"/> Gang influence |
| <input type="checkbox"/> Poor attendance | <input type="checkbox"/> Behavior problems | <input type="checkbox"/> Teased by peers |
| <input type="checkbox"/> Refused to go to school | <input type="checkbox"/> Other problems - Please describe: | |

Please comment on any of the above checked items:

This year’s school grades: (circle one)	Excellent	Good	Fair	Poor
Child’s school behavior: (circle one)	Excellent	Good	Fair	Poor

Therapist Notes:

MEDICAL INFORMATION

Current Physician: _____ Phone: _____

Physician's Address: _____

When was your child's most recent complete physical examination? _____

Has your child/adolescent suffered from any of the following medical conditions during his/her lifetime?

- | | | |
|---|--|---|
| <input type="checkbox"/> A serious accident | <input type="checkbox"/> Surgery | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> A head injury | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Hospitalizations |
| <input type="checkbox"/> High fevers | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pregnancy/miscarriage |
| <input type="checkbox"/> Stomach aches | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Speech/language problems |
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Chronic pain | <input type="checkbox"/> A sexually transmitted disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other |

Please describe any checked items, noting your child's age at the time of onset:

List any current health concerns:

Current medications: None

<u>Medication</u>	<u>Dosage</u>	<u>Date First Prescribed</u>	<u>Prescribed By</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current over-the-counter medications: (please include vitamins, herbal remedies, etc.)

Allergies and/or adverse reactions to medications: None (If yes, please list):

Therapist Notes:	
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