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.)

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___ Withdrawn/isolated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

Child/Adolescent Information Form

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:

Therapist Notes:

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:

___ Neglect	___ Emotional abuse	___ Physical abuse
___ Sexual abuse	___ Loss of a loved one	___ Natural disaster
___ Teenage pregnancy	___ Parental substance abuse	___ Crime victim
___ Violence in the home	___ Parents separated or divorced	___ Financial problems
___ Parental illness	___ Homelessness	___ Lived in a foster home
___ Multiple family moves	___ 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								
Marijauna								
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?

___ Fighting	___ Suspension	__ Poor grades
___ Lack of friends	___ Leaning problems	___ Detention
___ Incomplete homework	___ Smoking/alcohol/drugs	___ Gang influence
___ Poor attendance	___ Behavior problems	___ Teased by peers
___ Refused to go to school	___ 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?

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

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

List any current health concerns:

Current medications: ___ None

Medication	**Dosage**	**Date First Prescribed**	**Prescribed By**

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: