

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 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:
