## CHILD/ADOLESCENT INFORMATION FORM

Child Name: _____ Age: _____ DOB: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Gender: _____ Ethnicity: _____

Who referred you here? _____

Name of Parents/Legal Guardians: _____

Mobile Phone: (  )_____ OK to leave message? ___ Yes ___ No

Home Phone: (  )_____ OK to leave message? ___ Yes ___ No

Work Phone: (  )_____ OK to leave message? ___ Yes ___ No

Email: _____ OK to use? (see informed consent) ___ 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 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, diagnosis |
|---|---|---|---|---|
| Counseling or Psychiatric Care | | | | |
| Drug/Alcohol Treatment | | | | |
| Medication for mental health problem | | | | |
| Self-help/support group | | | | |

**CHILD'S PRESENTING PROBLEMS/CONCERNS**

Describe the problem(s) that brings you to treatment:

What do you hope to gain from therapy?

Please check behaviors and symptoms that problematically occur more often than what would be expected for the child's age (*trauma/abuse symptoms and school problems are listed on later pages)*:

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| ___ Computer addiction | ___ Hallucinations | ___ Phobias/fears | ___ Withdrawn/isolated |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

___ Other: _____

Briefly describe how the previous checked symptoms impair the child/adolescent's ability to function effectively:

Has he/she ever had thoughts or made statements of wanting to hurt him/herself or seriously hurt someone else? ___Yes ___ No. If yes, please describe the situation:

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

Please describe your child's strengths, skills, interests, hobbies, sports, and/or talents:

What do you enjoy doing with your child?

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

Would you like prayer to be part of therapy? ___ Yes ___ No. If yes, how?

**FAMILY & DEVELOPMENTAL HISTORY**

| Relationship | Name | Age | Deceased Y - N | Quality of Relationship |
|---|---|---|---|---|
| Mother | | | | |
| Father | | | | |
| Stepmother? | | | | |
| Stepfather? | | | | |
| Siblings? | | | | |
| | | | | |
| | | | | |
| | | | | |
| Spouse/partner? | | | | |
| Children? | | | | |

| Family mental health problems? | Who? | Family mental health problems? | Who? |
|---|---|---|---|
| Depression | | Bipolar | |
| Anxiety | | Imprisonment | |
| Sexual abuse | | Suicide | |
| Attention deficit | | Eating disorders | |
| Alcohol abuse | | Panic attacks | |
| Drug abuse | | Obsessive/ compulsive | |
| Schizophrenia | | Other: | |

**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:

Were there any complications with pregnancy or during birth? ___ Yes ___ No. If yes, please describe:

How would you describe your child's physical activity?

___ Inactive ___ Moderately active ___ Active ___ Very active

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

**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
___ A head injury
___ High fevers
___ Vision problems
___ Ear infections
___ Stomachaches
___ Abortion
___ Cancer
___ Seizures
___ Surgery
___ Meningitis
___ Hearing problems
___ Asthma
___ High blood pressure
___ Diabetes
___ Chronic pain
___ Heart problems
___ Thyroid problems
___ Allergies
___ Hospitalizations
___ Headaches
___ Loss of consciousness
___ Pregnancy/miscarriage
___ Speech/language problems
___ A sexually transmitted disease
___ 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):

Anything else you want me to know about your child or family?

**Therapist Notes**

| **THIS PAGE FOR OFFICE USE ONLY** | | | |
|---|---|---|---|
| **Client Name** | **Date** | **Duration (mins)** | **Location** |
| | | 53 | Office |
| **Others in session** | **Pr. Code** | **Session #** | |
| Parent | 90791 | 1 | |

**Mental Status:**

**Clinical Summary:**

**Diagnostic Impressions**:

**Treatment Plan:**

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