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CHILD AND ADOLESCENT INFORMATION

Child's Name_____ Birth date_____
Age_____ Sex_____ Race_____ Religious Affiliation (optional) _____

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'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
Name Age Lives with Child
_____ _____ 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
_____
_____
_____

Child's School_____ Grade_____

School Address_____
School Phone Number _____
School Contact Person _____
Relationship to Child _____

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.
_____
_____

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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

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___
Date Nature of Problem_____
Therapist _____
Benefit From Therapy?
_____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)
Description Age/Year
_____
_____

Is there a history of mental health issues in the family, such as (ADHD, anxiety, depression, schizophrenia, bi-polar, obsessive compulsive disorder, suicide, etc.?
Child _____
_____
Diagnosis_____
_____

Pregnancy and Delivery
Length of Pregnancy: Full Term Premature at _____ weeks Late by_____
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 Drug 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 _____

Child's Physician_____ Phone Number_____
Date of Last Medical Visit_____
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
High Fevers Never Past Present
Broken Bones Never Past Present
Stitches Never Past Present
Surgery (specify_____)
Never Past Present
Speech/Language Problems Never Past Present
Motor Problems (i.e., coordination problems: clumsiness (fine or gross motor),
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___

Please
describe_____

Referred by: _____Do I have your permission to thank your referral source? Yes __No___