Child/Adolescent Information Sheet Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Child's Name: _____

Date:_____ Birth date: _____/_____/_____ Age: _____

Gender _____

Address:

_____

__ City, State: _____ Zip:

_____

Parent/ Guardian Name(s):

_____ Home Phone:

(____) May I leave a message? □Yes □No Cell/Other Phone: (____)

May I leave a message? □Yes □No

E-mail: _____ May I email you? □Yes □No

*Please note: Email correspondence is not considered to be a confidential medium of communication. Referred by (if any):

_____

School:_____ Phone:_____ Teacher:_____

Grade: _____ How does your child do in school academically?

_____

How does your child do in school behaviorally?_____

Does your child have a learning or physical disability? __Y, __N, __Maybe. Specify:

_____

_____

_____

Does your child have a mental health diagnosis? __Y, __N, Specify:

_____

_____

_____

Does your family have specific spiritual beliefs?

_____

Medical History During pregnancy, did mother use: __ Cigarettes, __ Alcohol, __ Drugs, __ Experience Extreme Stress? Specify frequency, amounts, and duration:

_____

List any birth complications (Ex: Premature, jaundice, C-section, etc.)_____

_____

_____

List any Medical conditions or history (Ex: Surgeries, broken bones, allergies, etc.)_____

_____
_____
Does child use: __ Cigarettes, __ Alcohol, __ Drugs Specify amount and frequency:
_____
Primary Care Physician: _____ Phone:_____
Last seen on: _____ Psychiatrist: _____
Phone:_____ Last seen on: _____
Current medications: (Include dosage and
frequency):_____
_____
_____
Medication Allergies:
_____
Other Allergies:
_____
In the first two years, did your child experience: __Separation from mother __Out of home care, __Disruption in bonding __Depression of mother __Abuse __Neglect __Chronic pain __Chronic Illness __Parental Stress If yes, please specify:
_____
_____
_____
Reached developmental milestones: __On time, __Early, __Late
How many times has the child moved homes?
_____
What are five adjectives that describe: Primary Caregiver:
_____
Co-parent:
_____
___ Child:
_____
____ Parental Relationship:
_____
Family History Parent 1:_____
DOB:_____
Parent 2:_____ DOB:_____
___/___/___ Married; ___/___/___ Separated; ___/___/___ Divorced
Siblings (1st to last): Name: _____ Age:____ Name:
_____ Age: ____ Name: _____
Age:____ Name: _____ Age: ____ Name:
_____ Age:____ Name: _____ Age:
____ People in household, if different from above:
_____
_____

_____ Was your child adopted by either parent?: __Y, __N; If yes, the date you/they became caretaker: _____ Who is the primary caregiver for this child?
_____
Does Parent 1 work outside of the home? __Y, __N; Occupation: _____
Hours:_____ Parent 1's highest level of education:
_____
Does Parent 2 work outside of the home? __Y, __N; Occupation: _____
Hours:_____ Parent 2's highest level of education:
_____ If separated or divorced, visitation schedule: _____
What is custody arrangement regarding physical and mental health care:
_____
_____
____ Does either parent have legal issues?
_____
List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):
_____
_____
_____
_____
_____
Have children witnessed domestic violence? __Y, __N, Specify:
_____
_____
_____
How is your child disciplined? Please list each method and frequency of use:
_____
_____
_____
_____
_____
Trauma History Has your child been verbally abused? __Y, __N, __Suspected. Specify:
_____
_____
_____
Has your child been physically abused? __Y, __N, __Suspected. Specify:
_____
_____
_____
Has your child been sexually abused? __Y, __N, __Suspected. Specify:
_____

_____
_____
Other stressors or traumas?
_____
_____
_____
Circle the symptoms your child/adolescent displays and list the number of times per week it is displayed:
Anger Anxiety Bed wetting Acts out sexually Conduct problems Controlling Defecation Has unusual sexual knowledge Day wetting Defiance Depression Homicidal thoughts/ Disassociates actions Drug or alcohol use Hyperactivity Masturbates excessively Hyper vigilance Impaired conscience Isolation Lack of empathy Lack of motivation Lethargy Low impulse control Plays out violent themes Low self-esteem Lying Nightmares Plays out sexual themes Obsesses Over/Under eating Phobias Peer problems Phobias Running Away Shy Sleeplessness Stealing Tantrums Somatic Symptoms: Headaches/Stomachaches, etc. Other:
_____
___
_____
___ How does your child/adolescent handle anger?
_____
_____
_____
Has the child/adolescent experienced any significant loss? If yes, explain:
_____
_____
_____
What do you view as your child/adolescent ’s major strengths and positive traits?_____
_____
_____
What are your child/adolescent’s hobbies?
_____
_____
_____
What are your child/adolescent’s responsibilities at home?
_____
_____
_____
How well does your child/adolescent’s handle these responsibilities?
_____
_____
_____

Briefly describe your goals for your child/adolescent's therapy:

_____
_____
_____
_____
_____
_____

Please list any information you deem to be important for the therapist to know:

_____
_____
_____
_____
_____
_____
_____
_____

Who shall I contact in case of emergency? Name:

_____

Phone (_____)_____

Relationship _____

In this box, please indicate the address and telephone number you want me to use to when sending bills or when I need to contact you. If this box is left blank, I will use the address and any of the telephone numbers you have provided above. If you do not want me to leave a message on your answering machine, please tell me how you want me to reach you by phone: