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.):

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____

Have children witnessed domestic violence? __Y, __N, Specify:

____

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____

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: