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**Adolescent/Child Information Form**

*\*This Form is Completely Confidential\**

Today's date: \_\_\_\_\_

Your child's name: \_\_\_\_\_  
Last First Middle Initial

Child's date of birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Parent or Legal Guardian's Name: \_\_\_\_\_  
(Primary Subscriber if using insurance) Last First Middle Initial

Parent or Legal Guardian's date of birth: \_\_\_\_\_

Home street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent or Legal Guardian's Name of Employer: \_\_\_\_\_

Parent of Legal Guardian's Occupation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Calls will be discreet, but please indicate any restrictions: \_\_\_\_\_

Referred by: \_\_\_\_\_

- May I have your permission to thank this person for the referral?
- If referred by another clinician, would you like for us to communicate with one another?

Person(s) to notify in case of any emergency: \_\_\_\_\_

Name Phone  
I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): \_\_\_\_\_

Please briefly describe your child's presenting concern(s): \_\_\_\_\_

What are your/your child's goals for therapy? \_\_\_\_\_

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? \_\_\_\_\_

**MEDICAL HISTORY:**

Please explain any significant medical problems, symptoms, or illnesses your child has had: \_\_\_\_\_

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**Current Medications** (if you need more room, please write on the back of this page):

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor	May I contact the doctor?

Previous medical hospitalizations (Approximate dates and reasons): \_\_\_\_\_

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Previous psychiatric hospitalizations (Approximate dates and reasons): \_\_\_\_\_

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Has your child ever talked with a psychiatrist, psychologist, or other mental health professional? (If yes, please list approximate dates and reasons): \_\_\_\_\_

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**FAMILY:**

Parent Name: \_\_\_\_\_

Parent Name: \_\_\_\_\_

Age: \_\_\_\_\_

Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

Occupation: \_\_\_\_\_

Highest Level of Education: \_\_\_\_\_

Highest Level of Education: \_\_\_\_\_

If the child's guardian is not a biological or adoptive parent, please describe your relationship with client:

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Are there any other primary care givers who have a significant relationship with your child? If so, please describe how these people may have impacted your child's life: \_\_\_\_\_

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**Siblings:**

Name	Age	Sex	Relationship (Briefly describe)	Please give location if NOT in household with client

How would you describe your child's relationships with his or her grandparents? \_\_\_\_\_  
\_\_\_\_\_

**SOCIAL SUPPORT, SELF-CARE, & EDUCATION:**

How would you describe your child's relationships with his/her peers? \_\_\_\_\_  
\_\_\_\_\_

Please briefly describe your child's self-care and coping skills: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your child's diet, weight, and exercise/activity patterns? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your child's hobbies, talents, and strengths? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current educational setting:**

Public  Private  Alternative  Boarding  Charter  Home  Vocational  GED  Other

Current Grade Level: \_\_\_\_\_  Skipped a grade (If so, which one \_\_\_\_\_?)  Been held back (If so, for which grade \_\_\_\_\_?)

Any testing for an IEP (Individualized Education Plan)?  Yes  No

History of/or current placement in special education?

For learning problems?  Yes  No For behavior problems?  Yes  No

How many hours per day? \_\_\_\_\_

Ever been expelled or suspended?  Yes  No Reason: \_\_\_\_\_

**FAMILY HISTORY OF:**

Issue	Who?	Past/Present (Please circle one)
Drug/Alcohol Abuse		Past/Present
Legal Trouble		Past/Present
Domestic Violence		Past/Present
Suicide		Past/Present
Physical Abuse		Past/Present

Issue	Who?	Past/Present (Please circle one)
Sexual Abuse		Past/Present
Depression		Past/Present
Anxiety		Past/Present
Psychiatric Hospitalization		Past/Present
Learning Disabilities		Past/Present
Military Involvement		Past/Present
Financial Distress		Past/Present

**PLEASE CHECK ALL THAT APPLY TO YOUR CHILD & *CIRCLE* THE MAIN PROBLEM(S):**

Difficulty With	Now	Past	Difficulty With	Now	Past	Difficulty With	Now	Past
Anxiety			Tantrums			Nausea		
Depression			Parents Divorced			Stomach Aches		
Mood Changes			Seizures			Fainting		
Anger or Temper			Cries Easily			Dizziness		
Panic			Problems w/ Friends			Diarrhea		
Fears			Problems in School			Shortness of Breath		
Irritability			Fear of Strangers			Chest Pain		
Concentration			Fighting with Siblings			Lump in Throat		
Headaches			Sexually Acting Out			Sweating		
Loss of Memory			History of Child Abuse			Heart Problems		
Excessive Worry			History of Sexual Abuse			Muscle Tension		
Wetting the Bed			Domestic Violence			Bruises Easily		
Trusting Others			Thoughts of Harming Someone Else			Allergies		
Communicating with Others			Thoughts of Harming Self			Often Makes Careless Mistakes		
Separation Anxiety			Attempted Suicide			Fidgets Frequently		
Alcohol/Drugs			Thoughts of Suicide			Impulsive		
Drinks Caffeine			Sleeping Too Much			Waiting His/Her Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Disrupted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		

Difficulty With	Now	Past		Difficulty With	Now	Past		Difficulty With	Now	Past
Head Injury				Sleeping Alone				Chills or Hot Flashes		

**Any additional information you would like to include:**

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