Restore Counseling Ministries
402 Office Park Drive STE 300-A • Birmingham, AL • 205-440-2909

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: _____
_____
_____
_____

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): _____
_____
_____

Previous psychiatric hospitalizations (Approximate dates and reasons): _____
_____

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

FAMILY:

Parent Name: _____
Age: _____
Occupation: _____
Highest Level of Education: _____

Parent Name: _____
Age: _____
Occupation: _____
Highest Level of Education: _____

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

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: _____
_____
_____

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 Disbilities		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: