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Client Information (Child/Adolescent)

Today's date: __________________ Child's name: _____________________________________

Person completing this form and relationship to child: ___________________________________

Are the child's parents divorced? ☐ Yes* ☐ No
**If yes, parent must produce a copy of the divorce decree indicating that he or she has the right to bring the child for treatment.*

Demographic Information

Date of birth: ___________________ Age: ___________________ Sex: ___________________

Home street address: ____ Apt: _______

City: __________________________ State: __________________ Zip: ___________________

Home phone: ____________________________ Cell phone: ____________________________

Email: ____

People child lives with (names, ages, relationships): ______________________________________

____

____

Presenting Concerns

What are the difficulties that you brought you here? _____________________________________

____

____

____

What do you hope to gain from treatment? ____

____

____

____

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Father

Father's name: ____________________________ Date of birth: _____________ Age: ______

Cell phone: _______________________________ Email: _________________________________

Highest grade completed in school: _____________ Year: ______ Major: _________________

Father's employer: ____________________ Position: ____________________________________

Mother

Mother's name: ____________________________ Date of birth: _____________ Age: ______

Cell phone: ________________________________ Email: ________________________________

Highest grade completed in school: ___________ Year: _______ Major: _________________

Mother's employer: _________________________ Position: _____________________________

Biological Family History

	Name	History of mental illness?
Father:	___________________________________	_______________________________________
Mother:	__________________________________	_______________________________________
Sibling:	__________________________________	_______________________________________
Other:	___________________________________	_______________________________________

Medical Background

Child's pediatrician: ________________________ Date of last physical exam: _______________

List any significant developmental delays: ____

____

____

List any medical conditions or allergies your child has: ____

____

____

List any medications, including dosage and frequency, your child is *currently* taking: _________

____

____

Prior Counseling

List all prior counseling, mental health treatment, or psychiatric hospitalizations: _____________

____

____

____

Was treatment helpful? Why or why not?____

____

____

Education

____

School child attends: _______________________________ Grade: ______________________

Does your child receive any school accommodations? If so, please describe: _________________

____

____

Other

Is there anything else that would be helpful to know? ___________________________________

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Symptom Checklist (Child/Adolescent)

Please check each item that describes a symptom you have experienced to any significant degree during the last month.

	Physical Symptoms		Psychological Symptoms
☐	Allergies	☐	Academic difficulties
☐	Appetite change	☐	Anxiety
☐	Backaches	☐	Apathy
☐	Cold hands and/or feet	☐	Bullies others
☐	Constipation	☐	Compulsive behavior
☐	Diarrhea	☐	Confusion
☐	Difficulty sleeping	☐	Cruel to animals
☐	Fatigue, lack of energy	☐	Crying spells
☐	Hair pulling	☐	Delusions (false ideas)
☐	Headaches [migraine or tension]	☐	Delusions (false ideas)
☐	Heart beats rapidly, even at rest	☐	Difficulty concentrating
☐	Jaw tension	☐	Disobedient/uncooperative
☐	Muscle cramps, spasms	☐	Feeling overwhelmed
☐	Nausea	☐	Forgetfulness
☐	Neck and shoulder pain	☐	Frequent irritability/Low frustration
☐	Nervous stomach	☐	Guilt
☐	Refusal to speak	☐	Hyperactivity
☐	Repetitive/recurrent behaviors	☐	Impulsivity
☐	Skin condition [e.g., rash]	☐	Intrusive, recurrent, unwanted thoughts
☐	Skin picking	☐	Irrational fears
☐	Speech difficulties	☐	Loneliness
☐	Stomach pain or ulcer	☐	Low self-esteem
☐	Tics	☐	Lying
☐	Tight muscles	☐	Mood swings
☐	Use of alcohol, cigarettes, or drugs	☐	Nightmares
☐	Weight change	☐	Sadness
☐	Wetting or soiling the bed	☐	School phobia/avoidance
		☐	Self-harm
		☐	Separation anxiety
		☐	Social difficulties
		☐	Suicidal ideation
		☐	Violent or destructive behavior

Other concerns: ____

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