CLIENT INFORMATION FORM-CHILD/ADOLESCENT

(to be filled out by parent/guardian)

DATE: ___________________________

CHILD'S NAME: ___________________________ AGE: _____ DATE OF BIRTH: ____________________

FORM COMPLETED BY: _________________________ RELATIONSHIP TO CHILD: ____________________

What are the main difficulties/problems for which your child is being seen? ________________________

____

When did these difficulties first begin? ____

____

How often do these difficulties occur? ____

Members in the household:

PERSON'S NAME	RELATIONSHIP TO CLIENT	AGE

Has your child experienced any of the following?

☐ Death of a parent ☐ Prolonged separation from a parent ☐ Sexual Abuse

☐ Divorce of parents ☐ Emotional abuse/neglect ☐ Physical abuse

☐ Witness to violence/community violence/domestic violence ☐ Other highly stressful/traumatic experiences:

Is there concern that your child is using/experimenting with drugs/chemicals? ☐ YES ☐ NO

If yes, please explain further:

____

____

Has the child previously received mental health services/counseling? ☐ YES ☐ NO

If yes, ☐ Outpatient clinic ☐ Day-treatment ☐ Residential Facility ☐ Inpatient/hospitalization

Previous diagnosis (if known): ____

Date/Year	Agency/Therapist

Reason(s) for discontinuing previous counseling:

____

____

Has your child experienced any major illnesses such as infectious diseases, autoimmune conditions? High fever, head injury, any surgeries or hospitalizations, etc.? ☐ YES ☐ NO

If yes, please explain and give ages: ____

____

Do you have any concerns for your child in the following areas?

Sleep	☐ YES	☐ NO	☐ UNKNOWN
Appetite	☐ YES	☐ NO	☐ UNKNOWN
Eating disorder	☐ YES	☐ NO	☐ UNKNOWN
Weight concerns	☐ YES	☐ NO	☐ UNKNOWN
History of illness	☐ YES	☐ NO	☐ UNKNOWN
Injuries	☐ YES	☐ NO	☐ UNKNOWN
Infectious Disease	☐ YES	☐ NO	☐ UNKNOWN
Allergies	☐ YES	☐ NO	☐ UNKNOWN
Panic Attacks	☐ YES	☐ NO	☐ UNKNOWN
Depression	☐ YES	☐ NO	☐ UNKNOWN
Anxiety	☐ YES	☐ NO	☐ UNKNOWN
PTSD/trauma	☐ YES	☐ NO	☐ UNKNOWN
ADHD	☐ YES	☐ NO	☐ UNKNOWN
Autism	☐ YES	☐ NO	☐ UNKNOWN
Bi-Polar/Mania	☐ YES	☐ NO	☐ UNKNOWN
Hallucinations/ Psychosis	☐ YES	☐ NO	☐ UNKNOWN
Learning disabilities	☐ YES	☐ NO	☐ UNKNOWN

Other history:

Past suicide attempts:	☐ YES	☐ NO	☐ UNKNOWN
Current suicidal thoughts:	☐ YES	☐ NO	☐ UNKNOWN
Past self-injury (cutting, etc.)	☐ YES	☐ NO	☐ UNKNOWN
Current self-injury (cutting, etc.)	☐ YES	☐ NO	☐ UNKNOWN

Approximate date of last physical: _______________ Primary Care Physician: _____________________

Clinic: ____ Phone #: ______________________________

Has the child ever been on any long-term medications (more than six months)? ☐ YES ☐ NO

Past Medications/Comments: ____

List any current medications the child is taking (include over the counter medications):

____

Does the child have a psychiatrist? ☐ YES ☐ NO

If yes, psychiatrist's name and clinic: ____

Has the child ever tried complimentary/alternative approaches? (Acupuncture, homeopathy, energy work, massage, nutrition/diet, essential oils, other)? ____

____

Any difficulties in pregnancy, labor, infancy, or development experience with this child? ☐ YES ☐ NO

If yes, please explain: ____

Were there changes in the child's primary caregivers during the first three years of life? If yes, please describe: ☐ YES ☐ NO ____

____

School Attending: ________________________________ Current grade in school: _________

Has your child experienced any academic or behavioral challenges at school? ☐ YES ☐ NO

If yes, please describe ____

Has the child been tested for special education/have an IEP/ 504 Plan? ☐ YES ☐ NO

Any recent changes in grades? ☐ YES ☐ NO

Is the child involved in the legal system in any way? ☐ YES ☐ NO

If yes, please describe ____

Please share any religious beliefs/traditions, spiritual practices or cultural considerations that are important to your child and/or your family: ____

____

Who is included in the child's support system? ____

____

Please share what you perceive as your child's strengths:

____

____

Does the child participate in any community activities (sports, job, church/place of worship, etc)?

____

FAMILY HISTORY

Has anyone in the family had a problem with mental health concerns in the past or present?

Child's father	yes	no	unknown
Child's mother	yes	no	unknown
Stepfather	yes	no	unknown
Stepmother	yes	no	unknown
Brother/sister	yes	no	unknown
Grandparents	yes	no	unknown
Other relatives	yes	no	unknown
Other	yes	no	unknown

Has anyone in the family had a problem with substance use concerns in the past or present?

Child's father	yes	no	unknown
Child's mother	yes	no	unknown
Stepfather	yes	no	unknown
Stepmother	yes	no	unknown
Brother/sister	yes	no	unknown
Grandparents	yes	no	unknown
Other relatives	yes	no	unknown
Other	yes	no	unknown

Please share any information that would be helpful for the therapist to know:

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