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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.

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 describe:_____

_____

Reached developmental milestones: __On time, __Early, __Late

How many times has the child moved homes? _____

What are five adjectives that describe:

Mother: _____

Father: _____

Child: _____

Parental Relationship: _____

Family History

Biological Dad:_____ DOB:_____

Biological Mom:_____DOB:_____

___/___/___ Married; ___/___/___ Separated; ___/___/___ Divorced

Siblings (1st to last):

Name: _____ Age:____ Name: _____ Age: ____

Name: _____ Age:____ Name: _____ Age: ____

Name: _____ Age:____ Name: _____ Age: ____

Custodial Adults (If not biological parents): Dad: _____ DOB:_____

Mom: _____ DOB: _____ Date became caretaker: _____

People in household, if different from above: _____

_____

Does father work outside of the home? __Y, __N; Occupation: _____ Hours:_____

Father's highest level of education: _____

Does mother work outside of the home? __Y, __N; Occupation: _____ Hours:_____

Mother'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.): _____

_____

_____

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

_____

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 other 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:

I hereby consent for Erica Wright, MFT to provide my child/adolescent with evaluation and treatment.

_____

Signature Date