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Child and Adolescent Information Form

Client Name: _____ DOB: _____

Name of person completing form: _____ Relationship: _____

Presenting Concern – Please describe the reason you are seeking counseling services at this time –

How would you rate the intensity of the problem or concern that led you to seek professional services?

Extremely Intense Moderately Intense Not Intense
5 4 3 2 1

Approximately how long has this concern been impacting your life? _____

Mental Health History

Please indicate symptoms you have experienced in the past 2 weeks: _____

Have you sought professional mental health treatment in the past? _____

If yes, when and by whom? _____

Do you currently see a psychiatrist? _____ If yes, who? _____

Have you experienced thoughts of suicide in the past? _____ If yes, when? _____

Have you ever attempted suicide in the past? _____ If yes, when? _____

Do you have any family members who have committed suicide? _____ If yes, what relation to you? _____

Have you experienced any history of verbal/physical/sexual abuse? _____ If yes, please explain:

Have you experienced any other form of trauma? _____ If yes, please explain:

Medical History

Do you have any chronic medical conditions? _____ If yes, please list:

Please list current medications, dosages and prescribing physician:

How often do you exercise? _____

Have you had any changes to your sleep pattern? _____ If yes, please explain: _____

Have you had any changes to your appetite? _____ If yes, please explain: _____

Do you use alcohol? _____ If yes, please describe the frequency of use and type: _____

Do you use tobacco? _____ If yes, please describe the frequency of use and type: _____

Do you use any other drugs? _____ If yes, please describe frequency of use and type: _____

Have you ever been in treatment for drug or alcohol dependence? _____ If yes, please list date and place of treatment: _____

Family History

Do you have any family history of mental health concerns? _____ If yes, please explain:

Who currently lives in your home with client? _____

How would you describe client's relationship with others in the family? _____

Are there any family concerns that you would like addressed in counseling? _____ If yes, please explain:

Social History

What activities does client find enjoyable? _____

How much time does client spend in front of a screen (i.e. television, videogames, computer)? _____

Has client experienced any legal problems? _____

Religious or Spiritual Preference _____

Educational History

Grade in School? _____ Name of school attending: _____

How is client performing in school academically? _____

Has there been a change in client's level of academic performance? _____ If yes, please explain: _____

Does client have an Individualized Education Plan (IEP)? _____

Does client have a 504 plan? _____

Do you feel that your child's needs are being met when at school? _____

Strengths

What are client's strengths?

Goals

What are goals for therapy?

Parent or Guardian Signature

Date

Reviewed by:

Therapist Signature

Date

Treatment goals reviewed with client and parent/guardian on _____.

Date

1.

2.

3.