Family Counseling
& PSYCHOLOGY CENTER
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Child/Adolescent Contact Information

Client Name: _____ Date of Birth: _____ Age: ___ Gender: _____

Name & Gender if different with your insurance company: _____

Address: _____
Street City State Zip Code

Social Security Number: _____

Insurance Information

Primary Health Insurance: _____

ID Number: _____ Group/Policy Number: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Relationship to Subscriber: _____ Subscriber Employer: _____

Subscriber Address: _____
Street City State Zip Code

Secondary Health Insurance (If Applicable): _____

ID Number: _____ Group/Policy Number: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Relationship to Subscriber: _____ Subscriber Employer: _____

Subscriber Address: _____
Street City State Zip Code

Financial Guarantor Information

(Financially Responsible Person, does NOT have to be the Insurance Policy Holder.)

Name: _____ Date of Birth: _____ Relationship: _____

Address: _____
Street City State Zip Code

Signature: _____ Today's Date: _____

Name: _____ D.O.B _____ ID # _____

Contact Information

Mother: _____ Legal Guardian? __Y __N Ok to Contact? __Y __N
Home Phone: _____
Work Phone: _____
Cell Phone: _____

Father: _____ Legal Guardian? __Y __N Ok to Contact? __Y __N
Home Phone: _____
Work Phone: _____
Cell Phone: _____

Step Mother: _____ Legal Guardian? __Y __N Ok to Contact? __Y __N
Contact #: _____
Step Father: _____ Legal Guardian? __Y __N Ok to Contact? __Y __N
Contact #: _____

Non-Parent Legal Guardian: _____ Legal Guardian? __Y __N Ok to Contact? __Y __N
Relationship to Youth: _____
Contact #: _____

Who should receive reminder calls:

Name: _____ Relationship: _____

Phone: _____ __Call __ Text __Email: _____

Emergency Contact (Other than the people noted above):

Name: _____ Contact #: _____

Relationship to Child _____

Primary Care Physician Information:

Current Physician/Office: _____

Address: _____
Street City State Zip Code

Phone Number: _____ Fax Number: _____

School Information:

Current School: _____ Primary Teachers Name: _____

Main Contact at School: _____ School Phone Number: _____

Name: _____ D.O.B _____ ID # _____

Presenting Problems and Concerns

Describe the problem that brought you here today: _____

_____

Please check all your child's behaviors and symptoms that you consider problematic:

- ○ Distractibility
- ○ Hyperactivity
- ○ Impulsivity
- ○ Boredom
- ○ Poor Memory/Confusion
- ○ Sadness/Depression
- ○ Hopelessness
- ○ Thoughts of Death
- ○ Self-Harm Behaviors
- ○ Crying Spells
- ○ Loneliness
- ○ Low Self Worth
- ○ Fatigue
- ○ Recurring, Disturbing Memories
- ○ Change in Appetite
- ○ Withdrawal from People
- ○ Anxiety/Worry
- ○ Panic Attacks
- ○ Fear Away from Home
- ○ Social Discomfort
- ○ Phobias
- ○ Obsessive Thoughts
- ○ Compulsive Behavior
- ○ Racing Thoughts
- ○ Wide Mood Swings
- ○ Suspicion/Paranoia
- ○ Hearing Voices
- ○ Visual Hallucinations
- ○ Defiance
- ○ Aggression/Fights
- ○ Homicidal Thoughts
- ○ Frequent Arguments
- ○ Irritability/Anger
- ○ Peer/Sibling Conflict
- ○ Stealing
- ○ Destroys Property
- ○ Running Away
- ○ Swearing
- ○ Curfew Violations
- ○ Lying
- ○ Manipulative Behavior
- ○ No/Few Friends
- ○ Eating Problems
- ○ Sleep Problems
- ○ Nightmares
- ○ Toileting Problems
- ○ Fire Setting
- ○ Work/School Problems
- ○ Legal Problems
- ○ Sexual Behavior
- ○ Computer Addiction
- ○ Alcohol/Drug Use
- ○ Lack of Motivation
- ○ View Pornography
- ○ Other: _____

Are your child's problems affecting any of the following?

- ○ Handling Everyday Tasks
- ○ Health
- ○ Housing
- ○ Self Esteem
- ○ Recreational Activities
- ○ Legal Matters
- ○ Relationships
- ○ Work
- ○ Finances
- ○ Hygiene
- ○ School
- ○ Other: _____

Has your child ever had thoughts, made statements, or attempted to hurt themselves? ___Yes ___No

If yes, please describe & answer questions below:_____

_____

- How often does your child have these thoughts? _____
- When was the last time they had thoughts of dying? _____
- Has anything happened recently to make them feel this way? _____
- On a scale of 1-10 (10 being the strongest) how strong is their desire to kill themselves currently? _____
- Would anything make it better? _____
- Have they ever thought about how they would kill themselves? _____
- Is the method they would use readily available? _____
- Have they planned a time for this? _____
- Is there anything that would stop them from killing themselves? _____
- Do they feel hopeless and/or worthless? _____
- Have they ever tried to kill or harm themselves before? _____
- Do they have access to guns? ____ If yes, please explain: _____

Name: _____ D.O.B _____ ID # _____

Has your child ever had thoughts, made statements, or attempted to hurt someone else? ___Yes ___No

If yes, please describe & answer questions below:_____
_____

- How often does your child have these thoughts? _____
- On a scale of 1-10 (10 being the strongest) how strong is their desire to kill someone else currently? _____
- Have they ever thought about how they would kill someone? _____
- Is the method they would use readily available? _____
- Have they planned a time for this? _____
- Do they feel hopeless and/or worthless? _____
- Have they ever tried to kill or harm someone else before? _____
- Do they have access to guns? ____ If yes, please explain: _____

Has your child recently been physically hurt or threatened by someone else? ___Y ___N

If yes, please describe: _____

_____

Please list information regarding family relationships.

Relationship	Name	Live with child?	Age	Quality of Relationship
Mother				
Father				
Stepmother				
Stepfather				
Siblings				
Other Relatives				

- ○ Parents legally married or living together.
- ○ Parents temporarily separated.
- ○ Parents divorced or permanently separated.
- ○ Mother Remarried. (Number of times _____)
- ○ Father Remarried. (Number of times _____)

Please check if your child has experienced any of the following types of trauma or loss:

○ Emotional Abuse	○ Neglect	○ Lived in a foster home
○ Sexual Abuse	○ Violence in the home	○ Multiple family moves
○ Physical Abuse	○ Crim Victim	○ Homelessness
○ Parent Substance Abuse	○ Parent Illness	○ Loss of a Loved One
○ Teen Pregnancy	○ Placed a child for adoption	○ Financial Problems

Name: _____ D.O.B _____ ID # _____

Were there any medical problems during the pregnancy or birth of your child? ___Y ___N

If yes, please describe: _____

_____

Did the biological mother use any tobacco, medication, street drugs, or alcohol while pregnant with this child?___Y___N

If yes, please describe: _____

_____

Did your child have any developmental delays in early childhood? (Crawling, walking, talking, toileting, etc.) ___Y ___N

If yes, please describe: _____

_____

Please note if any family members have experienced any of the following mental health problems.

Family Medical Health History	Who?
Hyperactivity/ ADHD	
Experienced Sexual Abuse	
Depression	
Bipolar Disorder	
Made Suicide Attempt	
Anxiety Problems	
Panic Attacks	
Obsessive-Compulsive Behavior	
Anger Problems/Abusive Behavior	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	
Autism	
Other	

Previous Mental Health Treatment

Yes	No	Type of Treatment	When?	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (Mental Health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-Help/Support Groups			

Name: _____ D.O.B _____ ID # _____

School Information

Current grade/placement: _____

	Name of School	Excellent	Good	Fair	Poor
Elementary School Grades					
Elementary School Behavior					
Middle School Grades					
Middle School Behavior					
High School Grades					
High School Behavior					

Has your child had any of the following difficulties at school?

- ○ Suspension
- ○ Incomplete Homework
- ○ Learning Problems
- ○ Referrals or Detentions
- ○ Poor Grades
- ○ Teased or Picked On
- ○ Speech Problems
- ○ Attendance Problems
- ○ Gang Influence
- ○ School Refusal
- ○ Other: _____

Does your child have an after-school provider? ___Y ___N If yes, who? _____

Has your child ever repeated or skipped a grade? ___Y ___N If yes, which one(s)? _____

Has your child ever received Special Education services? ___Y ___N If yes, please describe services received and reason for services: _____

_____

Name: _____ D.O.B _____ ID # _____

Substance Abuse History (For ages 12 & older or if applicable)

		Yes	No	Frequency	Amount
Tobacco	Current use (last 6 months)				
	Past Use				
Caffeine	Current use (last 6 months)				
	Past Use				
Alcohol	Current use (last 6 months)				
	Past Use				
Marijuana	Current use (last 6 months)				
	Past Use				
Cocaine/Crack	Current use (last 6 months)				
	Past Use				
Ecstasy	Current use (last 6 months)				
	Past Use				
Heroin	Current use (last 6 months)				
	Past Use				
Inhalants	Current use (last 6 months)				
	Past Use				
Methamphetamines	Current use (last 6 months)				
	Past Use				
Pain Killers	Current use (last 6 months)				
	Past Use				
PCP/LSD	Current use (last 6 months)				
	Past Use				
Steroids	Current use (last 6 months)				
	Past Use				
Tranquilizers	Current use (last 6 months)				
	Past Use				

Has your child had withdrawal symptoms when trying to stop using any substances? ___Y ___N

If yes, please describe: _____

Has your child gambled in the past 6 months? ___Y ___N If yes, let us know the following:

Has your child ever felt the need to bet more & more money? ___Y ___N

Has your child ever had to lie to people important to them about how much they gambled? ___Y ___N

Has your child ever had problems with work, relationships, health, the law, etc., due to their substance use? ___Y ___N

If yes, please describe: _____

How much time per day does your child spend:

Playing Video games: _____ Watching Television: _____

Using a computer: _____ Using a Mobile Device: _____

Does your child have unrestricted access to the internet? ___Y ___N

Name: _____ D.O.B _____ ID # _____

Medical Information

Date of last Physical Exam: _____

Has your child experienced any of the following medical conditions during their lifetime?

- ○ Allergies
- ○ Chronic Pain
- ○ Dizziness/Fainting
- ○ High Fevers
- ○ Miscarriage
- ○ Asthma
- ○ Surgery
- ○ Meningitis
- ○ Diabetes
- ○ Abortion
- ○ Headaches
- ○ Serious Accident
- ○ Seizures
- ○ Hearing Problems
- ○ Sleep Disorder
- ○ Stomach Aches
- ○ Head Injury
- ○ Vision Problems
- ○ Ear Infections
- ○ Sexually Transmitted Disease
- ○ Other:

Personal & Family Medical History

	Yes	No	Which Family Member:
Thyroid Disease			
Anemia			
Liver Disease			
Chronic Fatigue			
Kidney Disease			
Stomach or Intestinal Problems			
Cancer (type)			
Fibromyalgia			
Heart Disease			
Chronic Pain			
High Cholesterol			
High Blood Pressure			
Liver Problems			
Other			

Please list any CURRENT health concerns: _____

_____

_____

Past medical problems, surgeries, or non-psychiatric hospitalization: _____

_____

_____

Add additional personal or family history: _____

_____

_____

Current prescription medication: ___ None

Medication	Dosage	Date First Prescribed	Prescribed By	Taken For

Name: _____ D.O.B _____ ID # _____

Current over-the-counter medications or supplements. (Including vitamins, herbal remedies, etc.):

_____

_____

Allergies and/or adverse reactions to medications. ___Y ___N

If yes, please list: _____

_____

Please describe your child's social support network. Check all that apply.

○ Family	○ Neighbors	○ Friends	○ Students
○ Co-Workers	○ Support/Self-Help Group	○ Community Group	○ Religious/Spiritual Center

To which cultural or ethnic group does your child belong? _____

Is your child experiencing any difficulties due to cultural or ethnic issues? ___Y ___N If yes, please describe:

_____

How important are spiritual matter to your child? ___Not at all ___Little ___Somewhat ___Very Much

Would you like spiritual/religious beliefs to be incorporated into your child's counseling? ___Y ___N

Please describe your child's strengths, skills & talents? _____

_____

_____

Describe any special areas or interest or hobbies. (Art, books, physical fitness, etc.): _____

_____

_____

Legal Information

If the parents are separated or divorced, what is the current child custody/visitation arrangement? _____

_____

	Yes	No
Is your child currently the subject of a custody case?		
Has your child been a ward or the court with DHS/DCFS guardianship?		
Does your child have any legal offenses on record or pending in the courts?		

Print Name: _____ Sign Name:_____

Relationship to child: _____