DATE:_____

CHILD/ADOLESCENT
INDIVIDUAL FORM

CHILD/ADOLESCENT INFORMATION

Name_____

Address_____ City:_____Zip_____

Home Phone_____ Cell/Pager_____E-Mail_____

Child/Adolescent's BirthDate_____ Age_____ Sex_____ SS#_____

Who referred you to us?_____

PARENT OR GUARDIAN LIVING WITH CHILD/ADOLESCENT

Parent 1 Name_____

Date of Birth:_____Age:_____SS #:_____

Occupation_____ Employer_____

Work Address_____Zip_____

W. Phone_____ Cell/Pager:_____ E-Mail:_____

Parent 2 Name_____

Date of Birth:_____Age:_____SS #:_____

Occupation_____ Employer_____

Work Address_____Zip_____

W. Phone_____ Cell/Pager:_____ E-Mail:_____

SIBLINGS

Siblings	Age	Sex	Birthdate	SSN	Living at Home Yes	No

ADDITIONAL FAMILY INFORMATION

Is there any other person living in your household other than parents or siblings? Yes____ No____
If yes, please give each person's name and relationship to the child/adolescent.

Are biological parents divorced or separated? Yes____ No____ If yes, for how long?_____
Please provide name, address and telephone number of biological parent not in household.

BASIC HEALTH AND COUNSELING HISTORY

Good____ Fair____ Poor____ Date of last Physical Exam?_____

Name of Physician?_____ Phone_____

Is child/adolescent taking any prescription medication, over-the-counter medications, allergy medications, herbs, etc.? Yes_____ No_____ If yes,what? _____

_____

_____

Has child/adolescent ever been hospitalized? Yes_____ No_____ If so, for what?_____

_____

Were there any significant prenatal or perinatal events? Yes_____ No_____ If yes, what?_____

_____

Any physical, emotional, or mental condition now or in the past that I need to be aware of?

Yes____ No____ If yes, what_____

_____

Has child/adolscent ever had counseling in the past? Yes_____ No_____

If so, From_____To_____ With whom?_____

For what?_____

Does the child have any problems socially?_____

Intellectually?_____ Academically?_____

Child/Adolescent's current grade level? Pk4 K 1 2 3 4 5 6 7 8 9 10 11 12

CHEMICAL DEPENDENCY SCREENING

Does the child/adolescent use any of the following substances now or in the past?

Caffeine? Yes_____ No_____ If yes, type and amount? _____

Cigarettes? Yes_____ No_____ If yes, type and amount? _____

Alcohol? Yes_____ No_____ If yes, type and amount? _____

Illicit Drugs? Yes_____ No_____ If yes, type and amount?_____

Other substance abuse?_____

Comments? _____

RATE YOUR CHILD/ADOLESCENT'S CURRENT MENTAL STATUS

	G= Good	**F=Fair**	**P=Poor**	**Comments**
1. Memory/Short	G	F	P	
2. Memory/Long	G	F	P	
3. Insight/Judgement	G	F	P	
4. Attention	G	F	P	
5. Concentration	G	F	P	
6. Affect/Mood	G	F	P	
7. Eye Contact	G	F	P	
8. Body Movement	G	F	P	
9. Speech	G	F	P	
10. Impulse Control	G	F	P	

CURRENT REASONS FOR SEEKING COUNSELING

Briefly describe the problem for which you wish your child/adolescent to have counseling?

What would you like to see happen as a result of counseling?

The thing which concerns me the most right now is?

POLICY

A counseling session is normally 50 minutes. It is customary to pay your therapist after each session. A 24-hour cancellation notice is appreciated; otherwise the usual fee may be charged.

The therapist will maintain strict confidentiality. However, I understand that suicidal threats, homicidal threats, or child abuse will be reported.

I understand and give permission to my therapist to seek clinical supervision or consultation about my situation when necessary.

I understand that I have the right to refuse treatment at any time.

Parent Signature_____

Adolescent Signature_____

Psychotherapist Signature_____