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Child/Adolescent Client Information Form

Today's date: __________________

Child's Name:____
Last First Middle Initial

Child's Date of Birth:______________________________ Gender: ______________________________

Parent/Legal Guardian's Name:____
Last First Middle Initial

Home street address:____

City: ____________________________ State: ______________ Zip:______________

Home Phone: ______________________________ Child cell: ______________________________

Parent cell: ______________________________ Parent work phone: ________________________

Parent email: ____

Child email: ____

Please indicate any restrictions for phone or email contact: ______________________________
____

Parent or Legal Guardian's Name of Employer: ______________________________

Address of Employer: ____

City: ____________________________ State: ______________ Zip:______________

Sexual Orientation:

☐ Heterosexual ☐ LGBTQIA+ ☐ Prefer not to say

Ethnicity:

☐ Caucasian ☐ African ☐ American Latino/a ☐ Asian/Pacific
☐ Islander ☐ Bi/multiracial ☐ Other ______________________________

Referred by: ____

May I have your permission to thank this person for the referral? ☐ Yes ☐ No

If referred by another clinician, would you like for us to communicate with one another? ______________
____

Person(s) to notify in case of emergency: ______________________________
Phone: ____

Medical / Developmental History

Has your child had any significant developmental or medical problems? ☐ Yes ☐ No

Please explain significant developmental or medical problems, symptoms, or illnesses:

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____
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Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous medical hospitalizations (approximate dates and reasons): ______________________
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Previous psychiatric hospitalizations (approximate dates and reasons):______________________
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Has your child ever talked with a psychiatrist, psychologist, or other mental health professional?
(If yes, please list approximate dates and reasons): ______________________________
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What are your child's diet, weight, and exercise/activity patterns? ______________________
____

What are your child's diet, weight, and exercise/activity patterns? ______________________
____

Does your child/adolescent smoke cigarettes? ☐ Yes ☐ No
Does your child/adolescent vape? ☐ Yes ☐ No
Does your child/adolescent use drugs recreationally? ________________ ☐ Yes ☐ No
Has child/adolescent had legal or school problems related to above usages? _____________ ☐ Yes ☐ No

Comments about child/adolescent substance use: ______________________________
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Current Presenting Concerns

Please briefly describe your child's presenting concerns (why you are bringing your child to therapy):

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What are your/your child's goals for therapy? ______________________________
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At what age did you first notice that your child had any emotional and/or behavioral difficulties?
______ 0-12 months __________1-2 years __________ 3-5 years _________ 612 years _________ 13 or older

Problem/Symptom	Never	Rarely	Sometimes	Frequently	Most of the Time
Seems unhappy					
Withdrawn					
Irritable/Angry mod					
Gets very upset when something doesn't work out					
Suicidal thoughts/behavior					
Often anxious, fearful, worries					
Obsessive or compulsive behavior					
Separation anxiety					
Lack of self confidence					
Difficulty with change					
Difficulty making and keeping friends					
Socially awkward					
Bullies other children					
Assumes others won't like them					
Speech/language problems					
Learning problems					
Poor grades					
Trouble completing assignments					
Trouble focusing on schoolwork					
Doesn't listen to teachers					
Hyperactive behavior					
Highly distractible					
Substance use					
Self-harm					
Lying/cheating with parents/authority figures					
Fights with siblings					
Poor grades					

Problem/Symptom	Never	Rarely	Sometimes	Frequently	Most of the Time
Conflict with parents					
Performs repetitive rituals/movements/ gestures/speech (like rocking, spinning, or hand flapping)					
Obsessive interests					
Poor eye contact					
Prefers being or playing alone					
Speaks with abnormal tone or rhythm (like a singsong voice or robot-like speech)					
Overeating or obesity					
Other:					
Other:					

What are your child's main strengths?

a) At home: ____________________

b) At school: ____________________

c) Other: ____________________

What are your child's hobbies and talents? ____________________

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Please describe your child's…	Poor	Below Average	Average	Above Average	Excellent
Level of happiness					
Ability to feel good about self					
Ability to turn to relationships when something goes wrong					
Ability to seek attention in positive and pleasurable ways					

Family

Child's parents are: ☐ Married ☐ Divorced ☐ Separated ☐ Never married
☐ Deceased (specify: __________________ ☐ Other: __________________________

If parent(s) are divorced or deceased, how old was the child and how do you think this impacted them?

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How would you describe your relationship with your mother? ______________________________

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How would you describe your relationship with your father? _______________________________

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How would you describe your relationship with stepparents, if applicable?___________________

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Please describe your child's relationship with their grandparents:__________________________

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Were there any other primary care givers who have had a significant relationship with your child? If so, please describe how these people may have impacted your child's life:_________________________

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Child lives with: ____

Others that live in the household include: ____

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How many sisters does your child have?_____________________________ Ages?_________________
How many step/half-sisters does your child have? ____________________ Ages?_________________
How many brothers does your child have? ___________________________ Ages?_________________
How many step/half-brothers does your child have? ___________________ Ages?_________________

How would you describe your child's relationship with their siblings? ________________________

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Peer Relationships

Please describe child's ability to…	Poor	Below Average	Average	Above Average	Excellent
Initiate interaction with peers					
Develop and maintain friendships					
Enjoy friendships					
Appear satisfied with social life					
Get along with peers					
Overall, my child's social/ peer relationships are…					

Comments/concerns about peer relationships: ____

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School Functioning

School: ____ Grade: ________________

Please describe child's…	Poor	Below Average	Average	Above Average	Excellent
Grades					
Enjoyment of learning					
Study/homework habits					
Ability to attend/focus					
Ability to follow classroom rules					
Overall in school, my child is doing					

Comments/concerns about school/academic functioning:

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Stressful Life Events

Traumatic/Stressful Experience	Has this EVER happened?	Has this happened within the last year?
Separation / Divorce of parents		
Remarriage of parents		
Birth of siblings		
Physical abuse of child client		
Sexual abuse of child client		
Child witnessed domestic violence		
Child witnessed physical conflict between family members		
Child witnessed violence in the community		
Bullied in school or community		
Experienced significant medical illness		
Child has special needs		
Medical illness of parent		
Death of parent		
Death of close family member		
Family financial problems		
Loss of employment for parent(s)		
Marital / Couple conflict		
Family conflict		
Foster care		
Adoption		
Care in an orphanage		
Multiple moves		
Depression or anxiety in parent(s)		
Substance abuse in parent(s)		
Parent has significant mental illness		

Traumatic/Stressful Experience	**Has this EVER happened?**	**Has this happened within the last year?**
Family member had legal problems related to interaction with legal system / crime		
Other (please indicate):		
Other (please indicate):		

Briefly describe any history of abuse, neglect, and/or trauma: ____

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