

CHILD AND ADOLESCENT INFORMATION FORM

DATE _____

FILE# _____
(Office use only)

CHILD'S NAME _____ D.O.B. _____ AGE _____

ADDRESS: _____

WHO DOES THE CHILD RESIDE WITH? _____

SCHOOL: _____ GRADE: _____ SPECIAL EDUCATION: YES OR NO

MOTHER'S NAME: _____ PHONE: _____

ADDRESS: _____

CAN WE CONTACT YOU AT WORK? YES OR NO WORK NUMBER: _____

FATHER'S NAME: _____ PHONE: _____

ADDRESS: _____

CAN WE CONTACT YOU AT WORK? YES OR NO WORK NUMBER: _____

EMERGENCY CONTACT: _____ PHONE NUMBER: _____

LIST OTHERS LIVING AT HOME:

NAME AGE RELATIONSHIP

(If more lines are needed, please use the back)

WE HAVE COME TO THE GERHOLZ CENTER FOR (CHECK ALL THAT APPLY)

_____ ANXIETY	_____ ANGER ISSUES	_____ BEHAVIOR PROBLEMS
_____ CHILD CUSTODY ISSUES	_____ EATING DISORDERS	_____ LOSS FROM DEATH
_____ PARENT CHILD ISSUES	_____ PEER ISSUES	_____ PHYSICAL ABUSE
_____ SCHOOL DIFFICULTIES	_____ SEXUAL ABUSE	_____ SIBLING PROBLEMS
_____ SUICIDAL ISSUES	_____ OTHER (PLEASE DESCRIBE) _____	

WHAT RELIGION: PROTESTANT___ CATHOLIC___ MUSLIM___ OTHER___ NONE___

DO YOU ATTEND CHURCH? REGULARLY___ SOMETIMES___ SELDOM___ NEVER___

DOES YOUR CHILD ATTEND CHURCH? YES NO SUNDAY SCHOOL? YES NO
YOUTH GROUP? YES NO

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PRESENTING PROBLEM(S)/CONCERNS: (CHECK ALL THAT APPLY)

- VERY UNHAPPY IMPULSIVE FIRE SETTING TEMPER OUTBURSTS
- IRRITABLE STUBBORN STEALING DISOBEDIENT
- LYING WITHDRAWN INFANTILE SEXUALLY ACTIVE
- DAYDREAMING MEAN TO OTHERS FEARFUL DESTRUCTIVE
- SCHOOL PERFORMANCE TRUANCY CLUMSY BEDWETTING
- TROUBLE WITH THE LAW OVERACTIVE RUNNING AWAY SOILS PANTS
- SELF-MUTILATING SLOW DISTRACTIBLE ROCKING
- EATING PROBLEMS SICK A LOT SHY USES DRUGS
- SLEEPING PROBLEMS USES ALCOHOL SUICIDE TALK PEER CONFLICT
- LACKS INITIATIVE UNDEPENDABLE PHOBIC STRANGE BEHAVIOR
- STRANGE THOUGHTS HEAD BANGING SEXUAL ABUSE SHORT ATTENTION SPAN
- CRUEL TO ANIMALS GETS INTO FIGHTS BAD LANGUAGE SUSPENDED FROM SCHOOL
- SUICIDE ATTEMPT (IF YES, WHEN? _____)

DEVELOPMENTAL AND HEALTH INFORMATION

WAS THE PREGNANCY PLANNED? YES___ NO___

DESCRIBE THE PREGNANCY (please circle all that apply)

- happy morning sickness tired smoked used alcohol drug use worried depressed
- spousal abuse relaxed employed money problems housing problems no insurance
- excited other?

FULL TERM PREGNANCY? YES NO WERE THERE ANY COMPLICATIONS? YES NO

IF YES, WHAT WERE THEY? Oxygen___ Breech birth___ C-section___ Forceps delivery___ "blue baby"___ premature___ other?___

IS YOUR CHILD ADOPTED? YES___ NO___ IF YES, AT WHAT AGE? ___

AT WHAT AGE DID YOU CHILD: SMILE___ ROLL OVER___ SIT UP___ CRAWL___ WALK___ SAY FIRST WORD___ TOILET TRAINED___

HAS YOUR CHILD EXPERIENCED ANY OF THE FOLLOWING?

- HIGH FEVERS PNEUMONIA FLU ASTHMA ALLERGIES ANEMIA
- ENCEPHALITIS MENINGITIS FAINTING HEADACHES CONVULSIONS CONCUSSION
- HEAD INJURY DIZZINESS UNCONSCIOUSNESS TONSILS OUT EARACHES
- HEARING PROBLEMS SURGERY VISION PROBLEMS WEIGHT PROBLEMS
- SKIN PROBLEMS ACCIDENT PRONE STOMACH PROBLEMS HEART PROBLEMS
- HYPERACTIVITY SINUS PROBLEMS BLOOD PRESSURE PROBLEMS
- OTHER? _____

HAS YOUR CHILD EVER BEEN HOSPITALIZED? YES NO

IF YES, PLEASE EXPLAIN: AGE___ HOW LONG___ REASON_____

IS YOUR CHILD ON ANY MEDICATION? YES NO

NAME OF MEDICATION DOSE FREQUENCY REASON FOR MEDICATION

NAME AND PHONE # OF FAMILY DOCTOR OR PEDIATRICIAN_____

NAME _____ FILE# _____

(Office staff only)

EDUCATION AND OTHER INFORMATION:

HAS YOUR CHILD EVER LIVED WITH ANYONE ELSE? YES NO

HAS YOUR CHILD EVER BEEN IN: FOSTER CARE RELATIVE'S HOME RESIDENTIAL PLACEMENT

WHO TOOK CARE OF YOUR CHILD FROM: (CHECK ALL THAT APPLY) 0-3 3-5 5-10 10-12 13-15 15-18

MOTHER

FATHER

STEP PARENT

GRANDPARENT

OTHER RELATIVE

DAY CARE/BABYSITTER

HAS YOUR CHILD BEEN PART OF A CUSTODY DISPUTE? YES NO

DID YOUR CHILD ATTEND PRE-SCHOOL? YES NO

IF YES, HOW WOULD YOU DESCRIBE THE EXPERIENCE? _____

HAS YOUR CHILD BEEN HELD BACK IN SCHOOL? YES NO IF YES, WHAT GRADE? _____

IS YOUR CHILD IN SPECIAL EDUCATION? YES NO IF YES, WHAT TYPE? _____

HOW LONG IN SPECIAL EDUCATION? _____

WHAT IS YOUR CHILD'S BEST SUBJECT? _____ WORST SUBJECT? _____

HOW DOES YOUR CHILD GET ALONG WITH OTHER CHILDREN HIS OR HER AGE? GOOD FAIR POOR

DOES YOUR CHILD DO BETTER WITH YOUNGER CHILDREN? YES NO

OLDER CHILDREN? YES NO

HOW MANY FRIENDS DOES YOUR CHILD/ADOLESCENT HAVE? 1 2-3 3 OR MORE

DOES YOUR CHILD HAVE ANY HOBBIES? YES NO IF YES, WHAT ARE THEY? _____

WHAT KIND OF HELP DO YOU THINK YOUR CHILD/ADOLESCENT NEEDS?

HOW WILL YOU KNOW WHEN YOUR CHILD/ADOLESCENT IS FINISHED WITH COUNSELING? (What will be different?)

IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD? _____

SIGNATURE OF PARENT/GUARDIAN DATE

SIGNATURE OF CHILD/ADOLESCENT DATE