Name: ______________________________________ Date: ______________________________________

Child/Adolescent Information Form
Lori Elderkin, LPC, CADCI

Welcome to our office. Please complete the following questionnaire which will be helpful in planning our services for you. If you need clarification on any question please do not hesitate to call or ask at time of session.

CLIENT INFORMATION

Full Name: ______________________________ Today's Date_________________________

Address: ____

City: ___________________________________ Zip: ________________________________

Home Phone: _________ Work Phone: ____________ Cell Phone: ______________________

Email Address: ____

Age: ______________________ Birth Date: ____________________________

Occupation/Job Title: ____

Employer/School: ____

Parent/Guardian Information (circle one):

Name/Relationship: _______________________ Name/Relationship:_______________________

Occupation: _____________________________ Occupation: _____________________________

Contact Phone Number: ___________________ Contact Phone Number: _____________________

Insurance Information (You will need your card at first session):

Insurance Company: ____

Insurance Phone Number(Back of Card): ____

Subscriber ID#: __________________________Group#:________________________________

Primary Subscriber: _____________________ Copay: Yes / No Amount:____________

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Name: ____ Date: ____

PRESENTING PROBLEMS AND CONCERNS

Presenting Problem:
____
____
____

Behaviors and Symptoms that are problematic:

☐ Distractibility
☐ Hyperactivity
☐ Impulsivity
☐ Boredom
☐ Poor Memory/confusion
☐Seasonal mood changes
☐ Sadness/Depression
☐Loss of pleasure/interest
☐Hopelessness
☐Thoughts of death
☐ Self-harm behaviors:____________
☐ Crying spells
☐ Loneliness
☐ Low self worth
☐ Guilt/shame
☐ Fatigue
☐ Lying
☐ Manipulative Behavior
☐ Change in Appetite
☐Phobias
☐ Withdrawal from people
☐ Anxiety/worry
☐ Panic attacks
☐ Fear away from home
☐ Social discomfort
☐ Obsessive thoughts
☐ Compulsive behavior
☐ Aggression/fights
☐ Frequent arguments
☐ Irritability/anger
☐ Homicidal thoughts
☐ Peer/sibling conflict
☐ Hearing voices/hallucinations
☐ Curfew Violations
☐ Fire setting
☐ No/Few Friends
☐ Suspicion/Paranoia
☐ Racing Thoughts
☐ Excessive energy
☐ Wide mood swings
☐ Sleep problems
☐ Nightmares
☐ Eating problems
☐ Stealing
☐ Destroys property
☐ Running away
☐ Swearing
☐ Sexual behavior
☐ Toileting problems
☐ Work/school
☐ Alcohol/drug use
☐ Computer addiction
☐ Defiance
☐ Other: __________

Areas affected by problems:

☐ Handling everyday tasks
☐Work/school
☐Recreational activities
☐Self esteem
☐Housing
☐ Health
☐ Relationships
☐ Legal matters
☐ Hygiene
☐Finances

☐ Yes ☐ No Suicidal Ideation/Attempts:
____
____

☐ Yes ☐ No Homicidal Ideation/Attempts:
____
____

☐ Yes ☐ No Physical/Emotional/Sexual Abuse:
____
____

Therapist Notes:
Initial: _______

Name: ____ Date: ____

FAMILY AND DEVELOPMENTAL HISTORY

Relationship	Name	Age	Quality
Mother			
Father			
Stepmother			
Stepfather			
Sibilings			
Spouse/partner			
Children			

Family Mental Health Problems	Who?
Hyperactivity	
Sexually Abused	
Depression	
Manic Depression	
Suicide	
Anxiety	
Panic Attacks	
Obsessive Compulsive	
Anger/Abusive	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	

☐ Parents Legally married or living together
☐ Parents temporarily separated
☐ Parents divorced or permanently separated

☐ Mother remarried: Number of times ___________
☐ Father remarried: Number of times ___________

Trauma or Loss:

☐ Emotional abuse
☐ Sexual abuse
☐ Physical abuse
☐ Parent substance abuse
☐ Teen pregnancy
☐ Neglect
☐ Violence in the home
☐ Crime victim
☐ Parent Illness
☐ Placed a child for adoption
☐ Lived in a foster home
☐ Multiple family moves
☐ Homelessness
☐ Loss of a loved one
☐ Financial problems

☐ Yes ☐ No Were there any medical problems during the pregnancy or birth? If yes, please explain:
____

☐ Yes ☐ No Did the biological mother use any tobacco, medication, street drugs, or alcohol while pregnant? If yes, please explain: -
____

☐ Yes ☐ No Did your child have any developmental delays in early childhood (crawling, walking, talking, toileting, etc.)? If yes, please describe: ____

Therapist Notes:
Initial: _______

Name: ____ Date: ____

PREVIOUS MENTAL HEALTH TREATMENT

Yes	No	Type of Treatment	When?	Provider/Program	Reason for Treatment

Therapist Notes:
Init:_____

School Information

Current grade/placement: __________________--

This year's school grades:	☐ Excellent	☐Good	☐Fair	☐Poor
Past school grades:	☐ Excellent	☐Good	☐Fair	☐Poor
This year's school behavior:	☐ Excellent	☐Good	☐Fair	☐Poor
Past school behaviors:	☐ Excellent	☐Good	☐Fair	☐Poor

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

☐ Yes ☐ No Does your child have an afer-school provider? If so, who? ____-
☐ Yes ☐ No Has your child ever repeated or skipped a grade? If yes, which ones? _________________________________
☐ Yes ☐ No Has your child ever received special education services? ____
What does your child's teacher say about him/her? ____

Substance Use History (For ages 12 or older or applicable)

Substance Type	Current Use (Last 6 months)		Past Use	
Tobacco	☐ Y ☐ N Freq:	Amt:	☐ Y ☐ N Freq:	Amt:
Caffeine	☐ Y ☐ N Freq:	Amt:	☐ Y ☐ N Freq:	Amt:
Alcohol	☐ Y ☐ N Freq:	Amt:	☐ Y ☐ N Freq:	Amt:
Marijuana	☐ Y ☐ N Freq:	Amt:	☐ Y ☐ N Freq:	Amt:
Cocaine/Crack	☐ Y ☐ N Freq:	Amt:	☐ Y ☐ N Freq:	Amt:
Ecstasy	☐ Y ☐ N Freq:	Amt:	☐ Y ☐ N Freq:	Amt:
Heroin	☐ Y ☐ N Freq:	Amt:	☐ Y ☐ N Freq:	Amt:
Inhalants	☐ Y ☐ N Freq:	Amt:	☐ Y ☐ N Freq:	Amt:
Methamphetamines	☐ Y ☐ N Freq:	Amt:	☐ Y ☐ N Freq:	Amt:
Pain Killers	☐ Y ☐ N Freq:	Amt:	☐ Y ☐ N Freq:	Amt:
PCP/LSD	☐ Y ☐ N Freq:	Amt:	☐ Y ☐ N Freq:	Amt:
Steriods	☐ Y ☐ N Freq:	Amt:	☐ Y ☐ N Freq:	Amt:
Tranquilizers	☐ Y ☐ N Freq:	Amt:	☐ Y ☐ N Freq:	Amt:
Benzodiazepines	☐ Y ☐ N Freq:	Amt:	☐ Y ☐ N Freq:	Amt:

☐ Yes ☐ No Withdrawal Symptoms: amt, frequency, length of time

____
____

Name: ____ Date: ____

☐ Yes ☐ No Negative consequences (work, legal, relationships, health)

____

____

Therapist Notes:
Init:_____

MEDICAL INFORMATION

Date of last physical exam: ________________________________

Medical Symptoms during lifetime:

☐ Allergies ☐ Asthma ☐ Headaches ☐ Stomach aches
☐ Chronic pain ☐ Surgery ☐ Serious accident ☐ Head injury
☐ Dizziness/fainting ☐ Meningitis ☐ Seizures ☐ Vision problems
☐ High fevers ☐ Diabetes ☐ Hearing problems ☐ Miscarriage
☐ Sexually transmitted Disease ☐ Abortion ☐ Sleep disorder ☐ Other: _________________

Current Health concerns: ____

Current PCP: ____ Release Signed ☐ Yes ☐ No

Name: ____

Current prescription medications: ☐ None

Medication	Dosage	Date First Prescribed	Prescribed By

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

____

Allergies and/or adverse reactions to medications: ☐ None

____

Therapist Notes:
Init: ____

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Social support network:

☐ Family ☐ Neighbors ☐ Friends ☐ Students ☐ Co-workers ☐ Support/Self help groups
☐ Community groups ☐ Religious/spiritual Center (which one? ____)

Cultural/Ethnic Group/any difficulties:

____

____

How important are spiritual matters? ☐ Not at all ☐ Little ☐ Somewhat ☐ Very much
☐ Yes ☐ No Would you like this incorporated into your counseling?

Strengths/Skills/Talents ____
Hobbies/interests (art, books, fitness, etc.)

____

____

Therapist Notes:

Name: _______________________________________ Date: _______________________________________

Init: ______

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?
☐ Yes ☐ No Has your child ever been a ward of the court with DHS/CPS guardianship?
☐ Yes ☐ No Does your child have any legal offenses on record or pending in the courts?

☐ Yes ☐ No Convicted of a misdemeanor or felony?
____
____

Therapist Notes
Init: _____