



PERSONAL DATA – CHILD/ADOLESCENT

Personal Information				
Name (First, MI, Last)			Date	
Parent/Guardian Name(s) (First, MI, Last)				
Address		City	State	Zip Code
Other Address		City	State	Zip Code
Home Phone ()		Work Phone ()		Cell Phone ()
Where may we contact you? <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Address <input type="checkbox"/> Other Address			Where may we leave a message? <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Other:	
Age	Date of Birth (MM / DD / YYYY)	Social Security Number	Parents' Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Other	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female				
Custody Status (check all that apply) <input type="checkbox"/> Birth Parents <input type="checkbox"/> Mother Only <input type="checkbox"/> Adopted: Age at Adoption _____ <input type="checkbox"/> Other Relative, Specify: <input type="checkbox"/> Ward of the Court <input type="checkbox"/> Father Only <input type="checkbox"/> Separated/Divorced – Shared Parenting				
If parents are separated, divorced, or never married, what is the frequency of contact between non-custodial parent and your child/adolescent?				

Emergency Contact Information	
Emergency Contact Person	Contact Phone ()
Relationship to Client	May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No

Permission to Treat a Minor	
I _____ (Print Parent's or Guardian's Name) give permission to Jennifer Newby MSEd, LPC to provide mental health services to _____ (Print Minor Client's Name). I attest that I have legal custody of this child and am therefore allowed to initiate and consent for treatment.	
Signature of Parent/Guardian _____	Date _____
Signature of Minor (if age 13 or older) _____	Date _____

Developmental History	
Pregnancy, birth, and delivery of this child/adolescent (If problems, please describe) <input type="checkbox"/> Normal <input type="checkbox"/> Problematic <input type="checkbox"/> Do not Know	
Overall, child's early development was: <input type="checkbox"/> Slow <input type="checkbox"/> Normal <input type="checkbox"/> Rapid <input type="checkbox"/> Do not Know	
During the first three years of life, did your child frequently exhibit any problematic behavior(s)? (If problems, please describe) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not Know	
Are childhood immunizations up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not Know	

Living Situation			
My Living Situation:			
Household Member Names	Relationship	Age	Quality of Relationship

Secondary Household
Family Members Who Live in Both Households <input type="checkbox"/> Only Client <input type="checkbox"/> Client and (list):
Family Environment / Relationships Child/Adolescent Experiencing Problems with (check all that apply) <input type="checkbox"/> Father <input type="checkbox"/> Stepfather <input type="checkbox"/> Siblings <input type="checkbox"/> Child Care Provider <input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Step-siblings <input type="checkbox"/> None of the Above <input type="checkbox"/> Other (describe)
Family Members Ever Experienced Problems with Substance Abuse (Drugs/Alcohol) or Mental/Emotional Problems (If yes, describe) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not Know
Family Financial Concerns (If yes, describe) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not Know
Parent Marital / Couples Relationship(s) (Include items such as conflict, activities, and level of satisfaction) <input type="checkbox"/> Not Applicable
Other Family Concerns Not Listed Above (describe) <input type="checkbox"/> None

School Functioning
School Presently Attending
Parents' Highest Grade Completed Mother: _____ Father: _____
Client ID: _____

Educational Classification			
Regular Education Classroom, No Special Services <input type="checkbox"/> Yes <input type="checkbox"/> No If no, check all that apply.			
<input type="checkbox"/> Multiple disabilities (not deaf-blind)	<input type="checkbox"/> Orthopedic Impairment	<input type="checkbox"/> Autism	<input type="checkbox"/> Visual Impairment
<input type="checkbox"/> Deaf-Blindness	<input type="checkbox"/> Emotional Disturbance (SBH)	<input type="checkbox"/> Other Health Impaired (minor)	<input type="checkbox"/> Specific Learning Disability
<input type="checkbox"/> Deafness (hearing impairment)	<input type="checkbox"/> Mental Retardation (DH)	<input type="checkbox"/> Other Health Impaired (major)	<input type="checkbox"/> Traumatic Brain Injury
<input type="checkbox"/> Speech or Language Impairment	<input type="checkbox"/> Preschoolers with a Disability	<input type="checkbox"/> Current 504 Plan	<input type="checkbox"/> Other:
School Related Issues (check all that apply)			
<input type="checkbox"/> Academic Problems	<input type="checkbox"/> Met with School Counselor	<input type="checkbox"/> Advanced a Grade	<input type="checkbox"/> Transportation
<input type="checkbox"/> Peer Relationships	<input type="checkbox"/> Relationship with Teacher(s)	<input type="checkbox"/> Suspension/Expulsion	<input type="checkbox"/> Behavior
<input type="checkbox"/> Attendance	<input type="checkbox"/> Required Special Help	<input type="checkbox"/> Homework	<input type="checkbox"/> None of the Above
<input type="checkbox"/> Detention	<input type="checkbox"/> Tested by a School Psychologist (ADD, ADHD, Other)	<input type="checkbox"/> Held Back a Grade	<input type="checkbox"/> Other:
Involvement in Activities Outside the Home (Work, Hobbies, Sports, Volunteer Activities, etc.)			
Other Academic / School Concerns (including performance/behavioral problems due to Alcohol/Drug use)			
<input type="checkbox"/> None			

Medical History / Information						
Physical Health:	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	Height	Weight
Diagnosed/Current Treatment for Significant Health Problems?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:		<input type="checkbox"/> Do not Know		
Drug/Food Allergies?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:		<input type="checkbox"/> Do not Know		
Appetite changes in last six months?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:		<input type="checkbox"/> Do not Know		
Weight loss/gain in last six months?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:		<input type="checkbox"/> Do not Know		
Describe the nutritional value/balance of child's diet:	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor			
Any sleep disturbance in the past month?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:		<input type="checkbox"/> Do not Know		
Check any problems you have observed: (Describe)	<input type="checkbox"/> Dieting	<input type="checkbox"/> Excessive Exercise	<input type="checkbox"/> Unusual Eating Habits	<input type="checkbox"/> None		
Serious Illnesses, Accidents, Operations (issue/side effects/etc.)	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:				
Please answer the following questions to the best of your knowledge about your child/adolescent:						
Sexually Active	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Uncertain			
Uses Contraceptives	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Uncertain			
Has History of Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Uncertain			
Has History of Abortion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Uncertain			
Has Fathered a Child	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Uncertain			
Do you have any concerns regarding your child's sexual development? (Describe)	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Client ID:						

Risk of Harm			
Past Attempts to Harm Self or Others	<input type="checkbox"/> None	<input type="checkbox"/> Self	<input type="checkbox"/> Others
Comments:	<input type="checkbox"/> Property		
	<input type="checkbox"/> No Comments		
Current Risk of Harm to <u>SELF</u>	<input type="checkbox"/> None		
Comments:	<input type="checkbox"/> No Comments		
Current Risk of Harm to <u>OTHERS</u>	<input type="checkbox"/> None		
Comments:	<input type="checkbox"/> No Comments		
Other Considerations			
Has your child experienced or witnessed any of the following?	<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/> Emotional Abuse
If yes, describe:	<input type="checkbox"/> Sexual Assault/Rape	<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Other Trauma
Has your child:	<input type="checkbox"/> Physically Harmed Another Individual, Pet, or Small Animal	<input type="checkbox"/> Talked About or Attempted Suicide	<input type="checkbox"/> Started a Fire
	<input type="checkbox"/> Threatened to Physically Harm Anyone	<input type="checkbox"/> Cut or Mutilated Their Body	<input type="checkbox"/> Run Away from Home
	<input type="checkbox"/> None of the Above	<input type="checkbox"/> Other:	
Cultural/Ethnic/Racial issues that need consideration?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:	<input type="checkbox"/> Do not Know
Religious/Spiritual issues that need consideration?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:	<input type="checkbox"/> Do not Know
Sexual orientation issues that need consideration?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:	<input type="checkbox"/> Do not Know
Areas of difficulty your child/adolescent displays when performing daily activities (check all that apply)			
<input type="checkbox"/> Adapting to Changes	<input type="checkbox"/> Goal Setting	<input type="checkbox"/> Attending to Tasks	<input type="checkbox"/> Learning
<input type="checkbox"/> Problem Solving	<input type="checkbox"/> Following a Routine	<input type="checkbox"/> Aggression	<input type="checkbox"/> Self Care (grooming/hygiene)
<input type="checkbox"/> None of the Above	<input type="checkbox"/> Other (explain)		
Significant Events (check any that have occurred in your child/adolescent's life)			
<input type="checkbox"/> Change of School	<input type="checkbox"/> Serious Illness/Injury to Family Member/Friend	<input type="checkbox"/> Frightening Experience	<input type="checkbox"/> Divorce or Separation
<input type="checkbox"/> Move to a New Place	<input type="checkbox"/> Loss of Someone Close to Child	<input type="checkbox"/> Death in Family	<input type="checkbox"/> None of the Above
Select Current Behaviors and Symptoms (select all that apply)			
<input type="checkbox"/> Aggression	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Memory Impairment	<input type="checkbox"/> Sick Often
<input type="checkbox"/> Alcohol Abuse/Dependence	<input type="checkbox"/> Elevated Mood	<input type="checkbox"/> Mood Shifts	<input type="checkbox"/> Sleeping Problems
<input type="checkbox"/> Anger	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Suicidal Thoughts
<input type="checkbox"/> Antisocial Behavior	<input type="checkbox"/> Feeling Stressed/Overwhelmed	<input type="checkbox"/> Perfectionism	<input type="checkbox"/> Test/Performance Anxiety
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Financial Concerns	<input type="checkbox"/> Phobias / Fears	<input type="checkbox"/> Thoughts Disorganized
<input type="checkbox"/> Avoiding People	<input type="checkbox"/> Gambling	<input type="checkbox"/> Problems with School/Work	<input type="checkbox"/> Trembling
<input type="checkbox"/> Changes in Appetite	<input type="checkbox"/> Grief/Loss	<input type="checkbox"/> Procrastination	<input type="checkbox"/> Trouble with Career Decisions
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Reading/Study Skills Problems	<input type="checkbox"/> Withdrawal
<input type="checkbox"/> Cyber-Addiction	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Recurring Thoughts	<input type="checkbox"/> Worrying
<input type="checkbox"/> Depression	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Relationship Difficulty	
<input type="checkbox"/> Difficulty Adapting to Change	<input type="checkbox"/> Homesickness	<input type="checkbox"/> Religious/Spiritual Concerns	<input type="checkbox"/> Other:
<input type="checkbox"/> Difficulty Concentrating	<input type="checkbox"/> Hopelessness	<input type="checkbox"/> Self-Esteem Difficulties	
<input type="checkbox"/> Disorientation	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Self-injury(cutting, burning, etc)	
<input type="checkbox"/> Distractibility	<input type="checkbox"/> Irritability	<input type="checkbox"/> Sexual Addiction	<input type="checkbox"/> Other:
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Judgment Errors	<input type="checkbox"/> Sexual Difficulties/Concerns	
<input type="checkbox"/> Drug Abuse/Dependence	<input type="checkbox"/> Loneliness	<input type="checkbox"/> Shyness	
Client ID:			

Current Situation
Why have you brought your child/adolescent for counseling?
How long has this been a problem?
What have you done, or are doing, to resolve the problem (s)?
What do you hope to accomplish in counseling?

Mental Health Treatment History			
Outpatient Mental Health / Alcohol/Drug Treatment <input type="checkbox"/> None			
Agency Name	Current?	Past (Date)	Clinician Name
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Psychiatric Hospitalizations <input type="checkbox"/> None			
Hospital Name	Date of Service	Reason (suicidal, depression, etc.)	
Previous or Current Diagnoses (if known) <input type="checkbox"/> Not Known			
Reason(s) for Discontinuation <input type="checkbox"/> No Comments			
Other Comments Regarding Mental Health Treatment History <input type="checkbox"/> No Comments			

Current / Previous Medication Information						
<input type="checkbox"/> None						
List all current medications, as well as those used within past 5-7 years (prescription / OTC / herbal)						
Medication	Rationale	Dosage / Frequency	Current?	Compliance		
				Yes	No	Partial
			<input type="checkbox"/> Yes <input type="checkbox"/> No			
			<input type="checkbox"/> Yes <input type="checkbox"/> No			
			<input type="checkbox"/> Yes <input type="checkbox"/> No			
			<input type="checkbox"/> Yes <input type="checkbox"/> No			

Client ID:

Primary Care/Physician Information	
Primary Care Physician (include name, phone no., and address) <input type="checkbox"/> None	Date of Last Exam (MM / DD / YYYY) <input type="checkbox"/> Unknown
Psychiatrist <input type="checkbox"/> None	Other Prescribing Physician(s) <input type="checkbox"/> None

Alcohol / Drug History																														
Describe what you know about your child/adolescent's alcohol/tobacco/drug use:																														
Has anyone ever had concerns about your child's use of alcohol, prescription medication, or other drugs (including caffeine)? <input type="checkbox"/> Yes <input type="checkbox"/> No																														
Is there a history of substance abuse problems in your family? <input type="checkbox"/> Yes <input type="checkbox"/> No																														
Has your child ever experienced any of the following with his/her use of alcohol, tobacco, prescription medications, or other drugs? If yes, check all that apply. <input type="checkbox"/> Yes <input type="checkbox"/> No																														
<input type="checkbox"/> Change in Peers <input type="checkbox"/> Relationship Problems <input type="checkbox"/> School Problems <input type="checkbox"/> Work Problems <input type="checkbox"/> Stealing from Family/Friends <input type="checkbox"/> Legal Problems <input type="checkbox"/> Emotional Problems <input type="checkbox"/> Mood Swings <input type="checkbox"/> Giving up Previously Enjoyed Activities <input type="checkbox"/> Physical Problems <input type="checkbox"/> Withdrawal Symptoms <input type="checkbox"/> Memory Lapse After Use <input type="checkbox"/> Increased Frequency/Quantity of Use <input type="checkbox"/> Caffeine Abuse																														
Drugs / Substances / Alcohol / Tobacco																														
<table border="1"> <thead> <tr> <th>Substance Name</th> <th>Age of 1st Use</th> <th>Date of Last Use</th> <th>Frequency of Use</th> <th>Amount</th> <th>Method</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	Substance Name	Age of 1 st Use	Date of Last Use	Frequency of Use	Amount	Method																								
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Legal History
Your Child's Current Legal Status (select all that apply) <input type="checkbox"/> None <input type="checkbox"/> On Probation <input type="checkbox"/> Detention <input type="checkbox"/> On Parole <input type="checkbox"/> Awaiting Charge <input type="checkbox"/> AoD Legal Problems <input type="checkbox"/> Conditional Release <input type="checkbox"/> OP Commitment <input type="checkbox"/> Court-Order Treatment
Your Child's History of Legal Charges/Involvement with Legal System (if so, please describe) <input type="checkbox"/> None
Legal Problems (or proceedings pending) Related to Other Family Members <input type="checkbox"/> None

Referral Information
How did you find out about our Counseling Center? (select all that apply) <input type="checkbox"/> Friend <input type="checkbox"/> Website <input type="checkbox"/> Doctor <input type="checkbox"/> Mental Health Professional <input type="checkbox"/> School <input type="checkbox"/> Court <input type="checkbox"/> Minister <input type="checkbox"/> Other: Please describe:

Signatures	
Client/Parent/Guardian Signature	Date (MM / DD / YYYY)
Therapist Signature	Date (MM / DD / YYYY)
Supervisor Signature	Date (MM / DD / YYYY)
Client ID:	