A · C · F
ADULT CHILD FAMILY
COUNSELING OF MASON

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?
☐ Home Phone ☐ Work Phone ☐ Cell Phone
☐ Address ☐ Other Address

Where may we leave a message?
☐ Home Phone ☐ Work Phone ☐ Cell Phone
☐ Other:

Age	**Date of Birth** (MM / DD / YYYY)	**Social Security Number**	**Parents' Marital Status**	**Gender**
			☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Widow ☐ Other	☐ Male ☐ Female

Custody Status (check all that apply)
☐ Birth Parents ☐ Mother Only ☐ Adopted: Age at Adoption _____ ☐ Other Relative, Specify:
☐ Ward of the Court ☐ Father Only ☐ 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?** ☐ Yes ☐ No

Permission to Treat a Minor

I _____ (Print Parent's or Guardian's Name) give permission to Samantha Rowe MS, 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) ☐ Normal ☐ Problematic ☐ Do not Know

Overall, child's early development was: ☐ Slow ☐ Normal ☐ Rapid ☐ Do not Know

During the first three years of life, did your child frequently exhibit any problematic behavior(s)? (If problems, please describe)
☐ Yes ☐ No ☐ Do not Know

Are childhood immunizations up to date? ☐ Yes ☐ No ☐ 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

☐ Only Client ☐ Client and (list):

Family Environment / Relationships

Child/Adolescent Experiencing Problems with (check all that apply)

☐ Father ☐ Stepfather ☐ Siblings ☐ Child Care Provider
☐ Mother ☐ Stepmother ☐ Step-siblings ☐ None of the Above
☐ Other (describe)

Family Members Ever Experienced Problems with Substance Abuse (Drugs/Alcohol) or Mental/Emotional Problems (If yes, describe)

☐ Yes ☐ No ☐ Do not Know

Family Financial Concerns (If yes, describe)

☐ Yes ☐ No ☐ Do not Know

Parent Marital / Couples Relationship(s) (Include items such as conflict, activities, and level of satisfaction)

☐ Not Applicable

Other Family Concerns Not Listed Above (describe)

☐ None

School Functioning

School Presently Attending

Parents' Highest Grade Completed

Mother: **Father:**

Client ID:

Educational Classification

Regular Education Classroom, No Special Services ☐ Yes ☐ No If no, check all that apply.

☐ Multiple disabilities (not deaf-blind)	☐ Orthopedic Impairment	☐ Autism	☐ Visual Impairment
☐ Deaf-Blindness	☐ Emotional Disturbance (SBH)	☐ Other Health Impaired (minor)	☐ Specific Learning Disability
☐ Deafness (hearing impairment)	☐ Mental Retardation (DH)	☐ Other Health Impaired (major)	☐ Traumatic Brain Injury
☐ Speech or Language Impairment	☐ Preschoolers with a Disability	☐ Current 504 Plan	☐ Other:

School Related Issues (check all that apply)

☐ Academic Problems	☐ Met with School Counselor	☐ Advanced a Grade	☐ Transportation
☐ Peer Relationships	☐ Relationship with Teacher(s)	☐ Suspension/Expulsion	☐ Behavior
☐ Attendance	☐ Required Special Help	☐ Homework	☐ None of the Above
☐ Detention	☐ Tested by a School Psychologist (ADD, ADHD, Other)	☐ Held Back a Grade	☐ 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)

☐ None

Medical History / Information

Physical Health:	☐ Excellent	☐ Good	☐ Fair	☐ Poor	**Height** / **Weight**
Diagnosed/Current Treatment for Significant Health Problems?	☐ No	☐ Yes, describe:	☐ Do not Know		
Drug/Food Allergies?	☐ No	☐ Yes, describe:	☐ Do not Know		
Appetite changes in last six months?	☐ No	☐ Yes, describe:	☐ Do not Know		
Weight loss/gain in last six months?	☐ No	☐ Yes, describe:	☐ Do not Know		
Describe the nutritional value/balance of child's diet:	☐ Good	☐ Fair	☐ Poor		
Any sleep disturbance in the past month?	☐ No	☐ Yes, describe:	☐ Do not Know		
Check any problems you have observed: (Describe)	☐ Dieting	☐ Excessive Exercise	☐ Unusual Eating Habits	☐ None	
Serious Illnesses, Accidents, Operations (issue/side effects/etc.)	☐ No	☐ Yes, describe:			

Please answer the following questions to the best of your knowledge about your child/adolescent:

Sexually Active	☐ Yes	☐ No	☐ Uncertain
Uses Contraceptives	☐ Yes	☐ No	☐ Uncertain
Has History of Pregnancy	☐ Yes	☐ No	☐ Uncertain
Has History of Abortion	☐ Yes	☐ No	☐ Uncertain
Has Fathered a Child	☐ Yes	☐ No	☐ Uncertain

Do you have any concerns regarding your child's sexual development? (Describe) ☐ Yes ☐ No

Client ID:

Risk of Harm

Past Attempts to Harm Self or Others ☐ None ☐ Self ☐ Others ☐ Property
Comments: ☐ No Comments

Current Risk of Harm to SELF ☐ None
Comments: ☐ No Comments

Current Risk of Harm to OTHERS ☐ None
Comments: ☐ No Comments

Other Considerations

Has your child experienced or witnessed any of the following? ☐ Physical Abuse ☐ Sexual Abuse ☐ Emotional Abuse
If yes, describe: ☐ Sexual Assault/Rape ☐ Domestic Violence ☐ Other Trauma

Has your child:

☐ Physically Harmed Another Individual, Pet, or Small Animal ☐ Talked About or Attempted Suicide ☐ Started a Fire
☐ Threatened to Physically Harm Anyone ☐ Cut or Mutilated Their Body ☐ Run Away from Home
☐ None of the Above ☐ Other:

Cultural/Ethnic/Racial issues that need consideration? ☐ No ☐ Yes, describe: ☐ Do not Know

Religious/Spiritual issues that need consideration? ☐ No ☐ Yes, describe: ☐ Do not Know

Sexual orientation issues that need consideration? ☐ No ☐ Yes, describe: ☐ Do not Know

Areas of difficulty your child/adolescent displays when performing daily activities (check all that apply)

☐ Adapting to Changes ☐ Goal Setting ☐ Attending to Tasks ☐ Learning
☐ Problem Solving ☐ Following a Routine ☐ Aggression ☐ Self Care (grooming/hygiene)
☐ None of the Above ☐ Other (explain)

Significant Events (check any that have occurred in your child/adolescent's life)

☐ Change of School ☐ Serious Illness/Injury to Family Member/Friend ☐ Frightening Experience ☐ Divorce or Separation
☐ Move to a New Place ☐ Loss of Someone Close to Child ☐ Death in Family ☐ None of the Above

Select Current Behaviors and Symptoms (select all that apply)

☐ Aggression	☐ Eating Disorder	☐ Memory Impairment	☐ Sick Often
☐ Alcohol Abuse/Dependence	☐ Elevated Mood	☐ Mood Shifts	☐ Sleeping Problems
☐ Anger	☐ Fatigue	☐ Panic Attacks	☐ Suicidal Thoughts
☐ Antisocial Behavior	☐ Feeling Stressed/Overwhelmed	☐ Perfectionism	☐ Test/Performance Anxiety
☐ Anxiety	☐ Financial Concerns	☐ Phobias / Fears	☐ Thoughts Disorganized
☐ Avoiding People	☐ Gambling	☐ Problems with School/Work	☐ Trembling
☐ Changes in Appetite	☐ Grief/Loss	☐ Procrastination	☐ Trouble with Career Decisions
☐ Chest Pain	☐ Hallucinations	☐ Reading/Study Skills Problems	☐ Withdrawal
☐ Cyber-Addiction	☐ Heart Palpitations	☐ Recurring Thoughts	☐ Worrying
☐ Depression	☐ High Blood Pressure	☐ Relationship Difficulty	
☐ Difficulty Adapting to Change	☐ Homesickness	☐ Religious/Spiritual Concerns	☐ Other:
☐ Difficulty Concentrating	☐ Hopelessness	☐ Self-Esteem Difficulties	
☐ Disorientation	☐ Impulsivity	☐ Self-injury(cutting, burning, etc)	
☐ Distractibility	☐ Irritability	☐ Sexual Addiction	☐ Other:
☐ Dizziness	☐ Judgment Errors	☐ Sexual Difficulties/Concerns	
☐ Drug Abuse/Dependence	☐ Loneliness	☐ 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 ☐ None

Agency Name	Current?	Past (Date)	Clinician Name
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		

Psychiatric Hospitalizations ☐ None

Hospital Name	Date of Service	Reason (suicidal, depression, etc.)

Previous or Current Diagnoses (if known)

☐ Not Known

Reason(s) for Discontinuation

☐ No Comments

Other Comments Regarding Mental Health Treatment History

☐ No Comments

Current / Previous Medication Information

☐ 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
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			

Client ID:

Primary Care/Physician Information

Primary Care Physician (include name, phone no., and address)
☐ None

Date of Last Exam (MM / DD / YYYY)
☐ Unknown

Psychiatrist
☐ None

Other Prescribing Physician(s)
☐ 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)? ☐ Yes ☐ No

Is there a history of substance abuse problems in your family? ☐ Yes ☐ 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. ☐ Yes ☐ No

☐ Change in Peers
☐ Relationship Problems
☐ School Problems
☐ Work Problems
☐ Stealing from Family/Friends
☐ Legal Problems
☐ Emotional Problems
☐ Mood Swings
☐ Giving up Previously Enjoyed Activities
☐ Physical Problems
☐ Withdrawal Symptoms
☐ Memory Lapse After Use
☐ Increased Frequency/Quantity of Use
☐ Caffeine Abuse

Drugs / Substances / Alcohol / Tobacco

Substance Name	Age of 1st Use	Date of Last Use	Frequency of Use	Amount	Method

Legal History

Your Child's Current Legal Status (select all that apply)

☐ None
☐ On Probation
☐ Detention
☐ On Parole
☐ Awaiting Charge
☐ AoD Legal Problems
☐ Conditional Release
☐ OP Commitment
☐ Court-Order Treatment

Your Child's History of Legal Charges/Involvement with Legal System (if so, please describe)
☐ None

Legal Problems (or proceedings pending) Related to Other Family Members
☐ None

Referral Information

How did you find out about our Counseling Center? (select all that apply)

☐ Friend ☐ Website ☐ Doctor ☐ Mental Health Professional ☐ School ☐ Court ☐ Minister ☐ 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: