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Child and Adolescent Information Form

Today's Date ______ / _______ / ________ Filled out by ________________________ Relationship to child _________________

Child's Full Name ____

Birth date _______ / _______ / ________ Age __________ Male ☐ Female ☐ Ethnicity/Race ______________________

Address ____
Street City State Zip Code

Presenting problems
What are your concerns about the child?

____

____

____

How long has he/she had the problem(s)____

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms that are *currently* present)
0 = Symptom is not present at this time
1 = Symptom present, but not enough to be a problem.
2 = Mild impact on quality of life (child typically functions okay)
3 = Moderate impact on quality of life and/or day-to-day functioning
4 = Serious impact on quality of life and strongly interferes with day-to-day functioning

Symptom	Severity	Symptom	Severity	Symptom	Severity
Alcohol problems	0 1 2 3 4	Stays out late/runs away	0 1 2 3 4	Sadness	0 1 2 3 4
Drug problems	0 1 2 3 4	Truant from school	0 1 2 3 4	Low self-esteem	0 1 2 3 4
Social/relational issues	0 1 2 3 4	Steals	0 1 2 3 4	Thoughts of death	0 1 2 3 4
Academic problems	0 1 2 3 4	Inattentive	0 1 2 3 4	Thoughts of harming self	0 1 2 3 4
Physically aggressive	0 1 2 3 4	Fidgets/squirms	0 1 2 3 4	Sleep problems	0 1 2 3 4
Verbally aggressive	0 1 2 3 4	Fails to finish things	0 1 2 3 4	Poor appetite	0 1 2 3 4
Bullies, threatens others	0 1 2 3 4	Difficulty playing quietly	0 1 2 3 4	Hears voices not there	0 1 2 3 4
Loses temper easily	0 1 2 3 4	Talks excessively	0 1 2 3 4	Sees things not there	0 1 2 3 4
Argues with adults	0 1 2 3 4	Is forgetful	0 1 2 3 4	Anxious/fearful	0 1 2 3 4
Defiant	0 1 2 3 4	Blurts out/interrupts others	0 1 2 3 4	Separation anxiety	0 1 2 3 4
Annoys others on purpose	0 1 2 3 4	Loses things	0 1 2 3 4	Physical complaints	0 1 2 3 4
Easily annoyed by others	0 1 2 3 4	Poor organization skills	0 1 2 3 4	Heart pounding/racing	0 1 2 3 4
Angry/irritable	0 1 2 3 4	Easily distracted	0 1 2 3 4	Unusual behaviors (explain):	0 1 2 3 4
Destructive to property	0 1 2 3 4	Low energy/fatigue	0 1 2 3 4		
Lies (to avoid trouble)	0 1 2 3 4	Unpredictable Moods	0 1 2 3 4		

EMOTIONAL/PSYCHIATRIC HISTORY
Has your child been in counseling before? ______ No ______ Yes:

Name of Counselor	**Counselor Address**	**Counselor Phone No.**	**Dates of service**	**How many sessions?**

Has your child ever been hospitalized for a psychiatric or substance use disorder? ______ No ______ Yes:

Name of facility	**City and state of facility**	**Facility phone number**	**Admission date**	**For how long?**

Does your child take any medication(s)? ______ No _______ Yes If yes, what medication(s) and for which condition(s)? __________________

____

Has any family member used psychiatric medication(s)? ______ No ______ Yes If yes, who/what/why (list all): which condition(s)?

____

Does your child have a history of physical or sexual abuse, neglect, witnessing domestic violence, trauma, prolonged separation, or abandonment?
_____ No _____ Yes, If yes, please provide details of experience (including type, age of onset, duration, and any apparent trauma effects):

____

____

Emotional health problems of family: (check all that apply)

	Mother	Father	Sister	Brother	Aunt	Uncle	Grandparents
Alcohol/drugs							
Anxiety							
Attention Deficit							
Bipolar Disorder							
Depression							
Eating Disorder							
Posttraumatic stress							
Schizophrenia							
Suicide attempt							

Family Relationships:
List other adults and children living in the home:

Name	Age	Gender	Relationship to Child	Quality of Relationship?
_____________________________	___________	______________	_______________________	Good ☐ Fair ☐ Poor ☐
_____________________________	___________	______________	_______________________	Good ☐ Fair ☐ Poor ☐
_____________________________	___________	______________	_______________________	Good ☐ Fair ☐ Poor ☐
_____________________________	___________	______________	_______________________	Good ☐ Fair ☐ Poor ☐
_____________________________	___________	______________	_______________________	Good ☐ Fair ☐ Poor ☐

Child's Development:
Please indicate if any of the following occurred during the pregnancy and developmental period for your child:

	No	Yes	If yes, please describe:
Medical problems during mother's pregnancy?	_______ No	________ Yes	_________________________________
Poor/inadequate prenatal care?	_______ No	________ Yes	_________________________________
Mother used drugs/alcohol/cigarettes during pregnancy?	_______ No	________ Yes	_________________________________
Mother experienced unusual stress during pregnancy?	_______ No	________ Yes	_________________________________
Labor or delivery problems?	_______ No	________ Yes	_________________________________
Child had problems during the newborn period?	_______ No	________ Yes	_________________________________
Developmental delays (walking, talking, toilet training, etc.)?	_______ No	________ Yes	_________________________________
Poor temperament in early childhood?	_______ No	________ Yes	_________________________________

Medical history

Describe current health: [ ] Good [ ] Fair [ ] Poor

Name of personal physician: ____

Address: ____ Phone number: _________________________

Name of psychiatrist (if any) : ____

Address: ____ Phone number: _________________________

Date of last physical exam: ____

List any abnormal test results: ____

Describe any serious hospitalizations or accidents:

Date _________________ Age ______ Reason ____

Date _________________ Age ______ Reason ____

Date _________________ Age ______ Reason ____

School History:

Child's school ____ Grade _____________________________________

Does/has your child…

	No	Yes	If yes, please describe:
have learning problems?	_________ No	__________ Yes	____
have behavior problems in school?	_________ No	__________ Yes	____
have social problems in school?	_________ No	__________ Yes	____
receive special help in school?	_________ No	__________ Yes	____
ever been held back a grade?	_________ No	__________ Yes	____
have other school problems?	_________ No	__________ Yes	____

Is it ok to contact school staff about child? _______ No _________Yes: Teacher/Staff ____

School Address ____ Phone ______________________
Street City State Zip Code

Please write down anything else you think we should know:

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