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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 <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>
_____	_____	_____	_____	Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>
_____	_____	_____	_____	Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>
_____	_____	_____	_____	Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>
_____	_____	_____	_____	Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>

Child's Development:

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

Medical problems during mother's pregnancy?	_____ No	_____ Yes	If yes, please describe:
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...			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:
