Client Clinical Information Sheet – Child/Adolescent (page 1)

*Below is a list of concerns people sometimes have. Consider each one, decide how much it has bothered your child or been a problem for your child during the past month, and then write a number (**1** = a little bit, **2** = some, **3** = a lot) in the space next to any that apply to indicate how much of a concern it is.*

___*Learning disabilities*
___*Other educational concerns*
___*Headaches*
___*Stomach Problems*
___*Other health problems*
___ *Over use of computer,internet, cell phone, or other electronics*
___*Increased appetite*
___*Nightmares*
___*Suicidal thoughts*
___*Lack of friends*
___*Other concerns*
*describe:*_____

___*Family problems*
___*Wetting or soiling self*
___*Oppositional behavior*
___*Speech Problems*
___*Anxiety, nervousness*
___*Self-control problems*
___*No appetite*
___*Loss of energy*
___*Weight loss*
___*Weight gain*
___*Violent behavior by your child*
___*Destructive behavior*

___*Over-activity*
___*Anger*
___*Feeling inferior*
___*Tantrums*
___*Withdrawn, isolated*
___*Feeling depressed*
___*Difficulty sleeping*
___*Relationship concerns with whom?*_____
_____
___*Self-esteem problems*
___*Misbehavior*

Does your child have a history of . . .

Abuse or trauma? ☐ *Yes* ☐ *No*
Psychiatric hospitalization? ☐ *Yes* ☐ *No*
Threatening or harming others? ☐ *Yes* ☐ *No*
Criminal behavior? ☐ *Yes* ☐ *No*
Seizure? ☐ *Yes* ☐ *No*
Suicide attempt? ☐ *Yes* ☐ *No*
Substance abuse? ☐ *Yes* ☐ *No*

Is there a family history of . . .

Domestic violence or abuse? ☐ *Yes* ☐ *No*
Mental illness? ☐ *Yes* ☐ *No*
Substance abuse? ☐ *Yes* ☐ *No*

Who is your child's primary care physician?
_____

If yes, please complete the following brief substance use history to the best of your knowledge:

	Currently using	*Method of use*	*Frequency of use*	*Amount*	*Age of first use*
Cigarettes	☐ *Yes* ☐ *No*				
Alcohol	☐ *Yes* ☐ *No*				
Marijuana	☐ *Yes* ☐ *No*				
Other (specify):					
Other (specify):					
Other (specify):					

Please list any medications (& dosages) your child is taking: _____
_____
_____

Please list any chronic or serious medical problems: _____
_____
_____

Current Household / Immediate Family / Key Persons: *Please list everyone who resides in your home, as well as other members of your immediate family not living in your home, and other key persons in your child's life below. Include yourself and your child in this listing. Choose several keywords (such as: quiet, angry, resentful, tired, nurturing, patient, trusting, etc.) to describe those listed below.*

First Name	*Relation to Client*	*Living at Home?*	*Age*	*Sex*	*Descriptive Keywords*
		☐ *Yes* ☐ *No*			
		☐ *Yes* ☐ *No*			
		☐ *Yes* ☐ *No*			
		☐ *Yes* ☐ *No*			
		☐ *Yes* ☐ *No*			
		☐ *Yes* ☐ *No*			
		☐ *Yes* ☐ *No*			
		☐ *Yes* ☐ *No*			

Relationships: *Which of the following describe how your child generally gets along with others?* *(Check all that apply)*

☐ *Affectionate* ☐ *Aggressive* ☐ *Avoidant* ☐ *Fight or argue often* ☐ *Peacemaker* ☐ *Friendly*
☐ *Follower* ☐ *Leader* ☐ *Outgoing* ☐ *Shy or withdrawn* ☐ *Submissive* ☐ *Other:* _____

Education: *Where does your child attend school?* _____

Does your child participate in any special education programs? ☐ *Yes* ☐ *No*

Has your child been evaluated for ADD, ADHD or other learning disability? ☐ *Yes* ☐ *No*

At school, is conduct /discipline a problem for your child? ☐ *Yes* ☐ *No*

What are your child's current estimated grades/grade average? _____

List any school-based or extracurricular activities in which your child participates: _____

_____

_____

_____

Spirituality/ Religion: *How important to you and your child are spiritual/religious matters?*

☐ *None* ☐ *Some* ☐ *Moderate* ☐ *Much*

Lifestyle: *List any hobbies, pastimes, or enjoyable activities in which your child regularly takes part:* _____

_____

_____

_____

_____

Support System: *List all social and family sources of support (for instance; neighbor, church, support group, etc.):*

_____

_____

_____

_____

Client Clinical Information Sheet – Child/Adolescent (page 3)

Please list any prior counseling experiences:

Name of agency or counselor: *Dates of service:* *Reason for counseling:*

What problems bring you to counseling and how long have they been a concern?

What changes do you hope will be made as a result of counseling?