Child/Adolescent Information Form

To determine how best to help you and your child, please completely provide the following information. Thank you very much for your time.

Child's Name:_____ Age:_____ DOB:_____ Today's Date _____
Address: _____ City: _____ State: ____ Zip: _____
Gender: Male __ Female __ Who referred you to Cornerstone: _____
Name of Parents/Legal Guardians: _____
Home Phone: ( ) _____ Ok to leave message? ____ YES ____ NO
Work Phone: ( ) _____ Ok to leave message? ____ YES ____ NO

WHO MAY WE CONTACT IN CASE OF EMERGENCY: _____
Daytime Phone: ( ) _____ Evening Phone: ( ) _____
Name of adolescent's work place (if applicable): _____

Legal Information

Was this child adopted? ____ YES ____ NO
Has this child ever been a ward of the court with DHS (formerly SCF) guardianship? ____ YES ____ NO
Has this child ever been the subject of a custody case? ____ YES ____ NO
Does this child have any legal offenses on record or pending in the courts? ____ YES ____ NO

If YES to any of the above, please describe the situation and the name of the DHS/OYA caseworker and/or the child's attorney's name: _____
_____

CHILD'S PREVIOUS MENTAL HEALTH TREATMENT

Type of Treatment	No	Yes	Start/End Dates	Provider name/ primary reason for treatment
Counseling or Psychiatric Care:				
Drug/Alcohol Treatment:				
Psychiatric Hospitalization:				
Medication for mental health problem:				
Self-help/support group:				

Therapist Notes: _____
_____
_____
_____
_____

CHILD'S PRESENTING PROBLEMS/CONCERNS

Describe the problem that brought you here today: _____
_____

What do you hope to gain from therapy: _____
_____

Please check behaviors and symptoms that occur more often than you would like:
(Note: Trauma/abuse symptoms are listed on page 4; school problems are listed on page 5.)

__ Aggression/fighting
__ Alcohol abuse
__ Angry outbursts
__ Arguments/conflicts
__ Anxiety
__ Avoiding people
__ Bedwetting/bowel problems
__ Computer addiction
__ Delinquency/runaway
__ Depression
__ Developmental delays
__ Distractibility
__ Drug abuse
__ Eating disorder
__ Elevated mood
__ Fatigue
__ Fire setting
__ Frequent illness
__ Hallucinations
__ Hopelessness
__ Hyperactivity/impulsivity
__ Inattention
__ Irritability
__ Loneliness
__ Low self-esteem
__ Memory problems
__ Mood swings
__ Panic attacks
__ Phobias/fears
__ Poor judgment
__ Obsessive thoughts
__ Oppositional defiance
__ Sexual acting out
__ Sleeping problems
__ Somatic complaints
__ Speech problems
__ Suicidal thoughts
__ Thoughts disorganized
__ Trembling
__ Withdrawn/isolated
__ Worrying
__ Other (specify)
__ _____
__ _____

Briefly describe how the above checked symptoms impair your child's ability to function effectively: _____
_____

Has he/she ever had thoughts or made statements of wanting to hurt themselves or seriously hurt someone else? __ YES __ NO. If YES, please describe the situation: _____
_____

Has he/she ever purposely hurt themselves or another? __ YES __ NO. If YES, please describe the situation:
_____
_____

Please describe your child's strengths, skills, interests and talents: _____
_____
_____

What would you like me to know about spiritual, religious, cultural, ethnic or other values or traditions in this child's family life?: _____
_____
_____

Therapist Notes: _____
_____
_____
_____
_____

FAMILY & DEVELOPMENTAL HISTORY

Relationship	Name	Age	Lives with Child?	Quality of relationship	Family mental health problems?	Who?
Mother:					Depression	
Father:					Anxiety	
Stepmother:					Sexual abuse	
Stepfather:					Attention deficit	
Siblings:					Alcohol abuse	
					Drug abuse	
					Schizophrenia	
					Manic-Depression	
					Imprisonment	
Other relatives:					Suicide	
					Eating disorders	
					Panic attacks	
					Obsessive/compulsive	

Parental Marital Information:

__ Parents legally married
__ Parents have been separated
__ Parents divorced

__ Mother remarried: Number of times _____
__ Father remarried: Number of times _____

If parents are separated or divorced, what is the current child custody and visitation arrangement? _____
_____
_____

Is there anything happening NOW in your current living situation or in your family that is especially stressful for the child or you? _____
_____

If any, please check the areas where your child had difficulties in early childhood

__ Feeding
__ Talking
__ Crawling/walking
__ Separation Anxiety
__ Sleeping
__ Riding tricycle
__ Riding bicycle
__ Dressing self
__ Toilet training
__ Tying shoes

Please describe the difficulties checked above: _____
_____

Please briefly describe how this child gets along with other children: _____
_____

Therapist Notes: _____
_____
_____
_____
_____

Did the child's biological mother use any tobacco, medication, street drugs, or alcohol during the pregnancy of this child? __ YES __ NO If YES, please describe what substances were used, as well as how much and how often the use occurred: _____
_____

Describe any medical problems that occurred during the pregnancy and/or birth of this child: _____
_____

Please check if this child has suffered any of the following types of trauma:

__ Neglect	__ Emotional abuse	__ Physical abuse
__ Sexual abuse	__ Loss of loved one	__ Natural disaster
__ Teenage pregnancy	__ Parental substance abuse	__ Crime victim
__ Violence in the home	__ Parents separated or divorced	__ Financial problems
__ Parental illness	__ Homelessness	__ Lived in foster home
__ Multiple family moves	__ Other: _____	

Please comment on any of the above checked items (including age of child at time of trauma and the details of the traumatic event): _____
_____
_____
_____

CHILD/ADOLESCENT CHEMICAL USE HISTORY

(Please complete if your child is 12 years or older)

Substance Type	Current Use (within the last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
PCP/LSD								
Heroin/opiates								
Methamphetamines								
Inhalants								
Other:								

Has your child had withdrawal symptoms when trying to stop using any substances? __ YES __ NO. If YES, please describe the situation: _____

Have any substances created a problem for your child at school, home or work? __ YES __ NO. If YES, please describe the situation: _____

Therapist Notes: _____
_____
_____
_____
_____

SCHOOL INFORMATION

Current School: _____ Primary Teacher's Name: _____
Current grade/placement: _____ How long at this school: _____
Main contact person(s) at school: _____

Does child have an after-school care-provider? __ YES __ NO If yes, which one(s): _____
What does this child's teacher(s) say about him/her? _____
_____

Other schools attended:
1) Headstart/preschool: _____
2) Elementary: _____
3) Middle School: _____
4) High School: _____

Has this child ever repeated/skipped a grade? __ YES __ NO If yes, which one(s): _____
Has this child ever received Special Education services? __ YES __ NO If yes, please describe the services received and the reason for services: _____
_____

Has this child exhibited any of the following difficulties at school?

__ Fighting	__ Suspension	__ Poor grades
__ Lack of friends	__ Learning problems	__ Detention
__ Incomplete homework	__ Smoking/alcohol/drugs	__ Gang influence
__ Poor attendance	__ Behavior problems	__ Teased by peers
__ Refused to go to school	__ Other problems- Please describe: _____	

_____

Please comment on any of the above checked items: _____
_____
_____

This year's school grades: (circle one): **Excellent** **Good** **Fair** **Poor**
Child's school behavior (circle one): **Excellent** **Good** **Fair** **Poor**

MEDICAL INFORMATION

Current Physician: _____ Phone: _____
Physician's Address: _____
When was your child's most recent complete physical examination? _____

Therapist Notes: _____
_____
_____
_____
_____

Has your child/adolescent suffered any of the following medical conditions during his/her lifetime?

__ A serious accident
__ A head injury
__ High fevers
__ Vision problems
__ Ear infections
__ Stomach aches
__ Abortion
__ Cancer
__ Seizures
__ Surgery
__ Meningitis
__ Hearing problems
__ Asthma
__ High blood pressure
__ Diabetes
__ Chronic pain
__ Heart problems
__ Other: _____
__ Allergies
__ Hospitalizations
__ Headaches
__ Loss of consciousness
__ Pregnancy/miscarriage
__ Speech/language problems
__ A sexually transmitted disease
__ Thyroid problems
__ Other: _____

Please describe any checked items noting your child's age at the time of onset: _____
_____

List any <u>current</u> health concerns: _____
_____

Current medications: __ None

Medication	Dosage	Date First Prescribed	Prescribed By
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current over-the-counter medications*: __ None (*includes vitamins, herbal remedies, etc.) _____
_____

Allergies and/or adverse reactions to medications: __ None (If yes, please list): _____
_____

THANK YOU FOR YOUR TIME AND EFFORT IN PROVIDING THIS HELPFUL INFORMATION!

Therapist Notes: _____
_____
_____
_____
_____