Child/Adolescent Application Form

I. General Information:

Today's Date:_____

Name of person completing this form:_____

Relationship to child/adolescent:_____

Who referred you? _____

Reason for referral: _____

Child/Adolescent's Last Name: _____ First Name:_____

MI:_____

Social Security #:_____Ethnicity:_____Gender:__M __F

Date of Birth:_____ Age:___Home Address: _____
_____

Mother's Name:_____Date of Birth:_____

Education: _____Occupation:_____

Father's Name:_____ Date of Birth:_____

Education: _____Occupation:_____

Step/adoptive/foster/grand/parents' name(please circle that apply):

Date of Birth:_____Education:_____

Occupation:_____

Parents are currently: Married___ Divorced___ Remarried___ Never Married___

Other_____

Are you currently involved in any divorce or child custody proceedings? Yes__No__

Who has legal custody of child/adolescent? Mom _____ Dad _____ Joint _____Other _____

Specify: _____
(if divorced, provide copy of custody order for file)

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List all those living in child's home:

Name	Relationship	DOB	Age	Gender

Languages spoken in the home: _____
List other persons closely involved with child/adolescent but not living in the home:_____
_____

mother/father/guardian preferred ok to leave message

Cell Phone: _____ ____
Home Phone:_____ ____
Work Phone:_____ ____

II. Child/Adolescent's Strengths:

What aspects of your child/adolescent's life or qualities are you pleased with?

_____
_____

What are your child's/adolescent's special skills and talent?

_____
_____

List your child/adolescent's hobbies, sports, recreational, musicals, TV, toy preferences, etc:

_____
_____
_____

How could you describe your child/adolescent's personality? _____
_____

What are some of your hopes and dreams you have for you and your child/adolescent?

_____
_____
_____

What role do spiritual/religious beliefs play in her/his life? _____

III. Current Problem:

What are your concerns about your child/adolescent that made you bring him/her to therapy?
_____

_____
_____
_____
_____

Describe prior assessment/therapy child/adolescent has received (Name of professional, date of service diagnosis):_____
_____
_____

IV. Family History (Mother/Father):
Physical Illnesses: _____
_____
Learning Problems: _____
_____
Mental Illnesses: _____
_____
_____

V. Client's Medical History:
List, if any, complications during pregnancy, at birth, delays in development, serious health issues, etc.:_____
_____
_____
_____

Is your child/adolescent taking any medications? If yes, list name/dosage, include over the counter medication.

Medication	Dosage/Frequency	Date Started	Physician who Rx	Side Effects	Effectiveness

Please list any known allergies: _____

Is your child/adolescent current with their immunizations? ___Yes ___ No

Has your child/adolescent been screened for vision, hearing, and speech? ___ Yes
____ No

What is the name of your child's/adolescent's pediatrician or physician?
_____Phone:_____

Any hospitalizations? _____

Any surgeries? _____

Any serious accidents? _____

Any infectious diseases? Yes__ No__ If yes, please describe _____

VI. School Information:
Name of school:_____

How many schools/child care programs has your child attended? _____

Has your child ever repeated a grade?____ If so which one(s)?____

Describe your adolescent's intellectual and academic abilities:

Has your child ever received special education services?

For Adolescents:
Any school suspensions?_____

Does he/she work?____ If so, where?_____ Problems there?____

Any problems with the law?_____

If over 12 yrs old, any past or present nicotine use _____

Any known problems with alcohol or drug use?_____
_____
_____

Any known problems with eating issues?_____
_____

Do you have any concerns about your adolescent's sexual development?_____
_____

Is your adolescent sexually active? ____ Problems with it?____

VII. Mental Health:
What are some of the things that are currently stressful to your child/adolescent and his/her family?
_____
_____
_____
Has your child/adolescent ever made statements of wanting to hurt him/her self? _____
_____
Has he/she ever purposely hurt himself/herself or another? _____

If yes to either question please describe the situation:_____
_____
Has your child/adolescent witnessed violence in the home or experienced other traumas (e.g., physical, sexual abuse)?_____
_____
Has your child/adolescent ever experienced any serious emotional losses (such as a death of or a physical separation from a parent or other caretaker)?_____ His/her reaction:_____
Has your child/adolescent been involved with the justice system or DHS? ____
If yes, please give history:_____
_____
_____
How does your child/adolescent relate to family members?_____
_____
Others:_____
Who generally disciplines the child/adolescent and how is the child/adolescent disciplined? _____
_____
_____

How many friends does he/she have?_____ Are they of the child's age or older/younger?_____
_____

With whom does your child/adolescent spend most of his/her free time?_____
_____

What are Your Goals for Counseling?

1._____
_____
2._____
_____
3._____
_____

What types of counseling services would you prefer (circle all that apply)?:

Individual Family Office-Based School-Based Home-Community Based

Thank you for taking the time to complete the form! This information will help me understand your situation better and will allow us to assist you in reaching your goals as quickly as possible.