Child / Adolescent Information Form

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CLIENT INFORMATION

Today's Date: ____ / ____ /____
Child's name: _____
Date of Birth: ____ / ____ /___ Age: ____ Grade Level: ___
School: _____
Does the child attend church? ☐ Yes ☐ No
Church Name _____
Child's custodian/guardian(s) is/are: _____
Child's Address: _____
City: _____ State: ____ Zip: _____

FATHER'S INFORMATION

Father's Name: _____Age: _____
Father's Address: _____
City: _____ State: ___ Zip: _____
Phone (Home)_____ (Work)_____
(Cell)_____
Occupation_____
Employer_____
Religious Affiliation: _____

Father's Marital Status: q Married q Engaged q Widowed q Divorced q Separated q Live with Partner q other ____

MOTHER'S INFORMATION

Mother's Name: _____ Age: _____
Mother's Address: _____
City: _____ State: ____ Zip: _____
Occupation_____
Employer_____
Religious Affiliation: _____
Phone (Home)_____ (Work)_____
Phone (Cell) _____
Mother's Marital Status: q Married q Engaged q Widowed q Divorced q Separated q Live with Partner q other _____

FAMILY COMPOSITION

Who currently resides in the same house as the child? Please include everyone including any half or step brothers and sisters names.

	Name	Age	Relationship
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Emergency Contact Information:
Name: _____
Phone: _____ Relationship: _____
Address: _____

How were you referred to our office? _____

_____

At times we may need to contact you in order to reschedule an appointment, provide a reminder, and/or provide some medical information. May we contact you? ☐ Yes ☐No

How would you like us to contact you? ☐ Phone Call ☐ Text ☐ E-mail ☐ Letter ☐ Other: _____

Can we leave a message for you ☐ Yes ☐No?

If so at what phone number: _____

Reason for Seeking Counseling:
State the nature of your problem in your own words that you are seeking counsel for.

_____
_____
_____

How long has this issue existed? ____

What is your child's most difficult relationship right now? _____

_____

What is your child's most difficult emotion right now? _____

_____

How does your child do in school academically? _____

_____

How does your child do in school behaviorally? _____

_____

Does your child have a learning or physical disability?
__Y, __N, __Maybe. Specify: _____

_____
_____

Does your child have a mental health diagnosis?
__Y, __N, Specify: _____

_____
_____

Briefly describe how your child would describe the 3 most problems for him/her right now. Please be as specific as possible.

1.
_____
_____

2.
_____
_____

3.
_____
_____

Child / Adolescent Information Form

CURRENT FAMILY STRESSORS

Have any of the following stressful events occurred within the past 12 months?

____ Parents divorced or separated	____ Death in family	____ Parent Changed Jobs
____ Family accident or illness	____ Changed Schools	____ Parent entered new relationship
____ Family financial problems	____ Family moved	____ Other

Rate each of the following life issue with the following **key: no issue=0; mild issue=1; moderate issue=2; severe issue=3.**

___Anger	___Defiance	___Isolation	___Acts out sexually
___Anxiety	___Lethargy	___Nightmares	___Lack of Empathy
___Conduct Problems	___Lying	___Phobias	___Masturbates excessively
___Lack of Motivations	___Over/Under Eating	___Shy	___Plays out violent themes
___Low Self-Esteem	___Running Away	___Sleeplessness	___Loneliness
___Obsesses	___Tantrums	___Low Impulse Control	___Hyperactivity
___Stealing	___Fear	___Peer Problems	___Day or Bed Wetting
___ Controlling	___Depression	___Somatic Symptoms: Headaches/Stomachaches, etc.	

Other: _____

How many times has the child moved homes? _____

How does your child handle anger? _____

Has the child experienced any significant loss? If yes, explain: _____

_____

What do you view as your child's major strengths and positive traits?

_____

_____

What are your child's hobbies?

_____

Briefly describe your goals for your child's therapy:

_____

_____

Please list any information you deem to be important for the therapist to know: _____

_____

Personality Data:

Circle any of the following words that best describe your child now:

Active	Shy	Hardworking	Leader	Compulsive
Nervous	Likeable	Impulsive	Follower	Excitable
Impatient	Self-conscious	Often-blue	Sarcastic	Serious
Moody	Jealous	Calm	Self-confident	Easy-going
Imaginative	Ambitious	Good-natured	Persistent	Quiet
Introverted	Extroverted	Fearful	Loner	Stubborn

Others: _____

COMPREHENSION AND UNDERSTANDING

Do you consider your child to understand directions and situations as well as other children his or her? Age? _____ If not, why not?

_____

_____

How would you rate your child's overall level of intelligence compared to other children their age?

Below Average _____Average _____Above Average _____

Child / Adolescent Information Form

Health Information
PRESENT MEDICAL STATUS

Rate your child's health: ☐Very Good ☐ Average ☐Poor

Weight changes recently: ☐None ☐Lost ☐Gained: _____

Height _____ Weight _____
Present illnesses for which the child is being treated_____
Any physical abnormalities_____

Name of your child's pediatrician or family doctor_____

List all-important present or past illnesses, injuries, or disabilities: _____
_____
_____

Physician's name: _____ Address: _____

Date of last medical exam: _____ Report: _____
_____

Is your child presently taking medication? ☐ Yes ☐No If yes list the medication and dosage:

MEDICATION	DOSAGE	TIMES PER DAY	REASON FOR TAKING

During pregnancy, did mother use: __ Cigarettes, __ Alcohol, __ Drugs, __ Experience Extreme Stress?

Specify frequency, amounts, and duration: _____

Problems with pregnancy, labor, or delivery of child_____
_____
List any birth complications (Ex: Premature, jaundice, C-section, etc.)_____
_____

List any Medical conditions or history (Ex: Surgeries, broken bones, allergies, etc.)_____
_____

Medication Allergies: _____

Other Allergies: _____

In the first two years, did your child experience: __Separation from mother, __Out of home care, __Disruption in bonding, __Depression of mother, __Abuse, __Neglect, __Chronic pain, __Chronic Illness, __Parental Stress

If yes, please specify: _____
_____

Reached developmental milestones: __On time, __Early, __Late

Child / Adolescent Information Form

In the first two years, did your child experience: __Separation from mother, __Out of home care, __Disruption in bonding, __Depression of mother, __Abuse, __Neglect, __Chronic pain, __Chronic Illness, __Parental Stress

If yes, please specify: _____
_____
_____

During the following periods did your child have problems with any of these?

INFANCY-first year

Did not enjoy cuddling_____
Was not calmed by being held or stroked_____
Difficult to comfort_____
Colic_____
Excessive restlessness_____
Excessive irritability_____
Diminished sleep_____
Frequent head banging_____
Problems with nursing or taking bottle_____
Constantly into everything_____

TODDLER - second to third year

Excessively active_____
Cranky/irritable_____
Withdrawn/fearful_____
Irregular patterns of sleep, appetite, habits_____
How many times has the child moved homes? _____

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and give pertinent details:

Childhood diseases (describe ages and any complications_____
_____
_____
Operations _____
Hospitalizations for illness/surgery_____
Loss of consciousness_____
Head injuries_____
Convulsions_____
With fever_____
Without fever_____
Coma_____
Persistent high fevers_____
Eye/vision problems_____
Tics (Example: eye blinking, sniffing, any repetitive, non-purposeful movements)_____
Ear/hearing problems_____

Child / Adolescent Information Form

Chronic ear infections/tubes_____
Thyroid problems_____
Allergies or asthma_____
Poisoning_____
Appetite/eating problems_____
Unusual cravings_____
Speech problems_____
Sleep problems_____
Clumsy/accident proneî_____
Problems with coordination_____
Problems with sexual development_____

What are five adjectives that describe your child's relationship with each of the following family member?
Mother: _____
Father: _____
Siblings: _____
People in household, if different from above: _____

How does your child deal with authority?: _____

Does father work outside of the home? __Y, __N; Occupation: _____Hours: _____
Father's highest level of education: _____
Does mother work outside of the home? __Y, __N; Occupation: _____ Hours: _____
Mother's highest-level f education: _____
If separated or divorced, visitation schedule: _____
_____
Does either parent have legal issues? _____

List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, Bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):
_____
_____

Does child use: __ Cigarettes, __ Alcohol, __ Drugs
Specify amount and frequency:_____

Have children witnessed domestic violence? __Y, __N, Specify: _____
_____

How is your child disciplined? Please list each method and frequency of use: _____
_____
_____
_____
_____
_____
_____

Child / Adolescent Information Form

Family History

Have any of the child's blood relatives (biological parents, grandparents, siblings, aunts, uncles, or close Cousins) experienced the following? Please specify which relative.

_____Reading problems_____
_____Attention problems_____
_____Hyperactivity_____
_____Developmental disorders/mental retardation_____
_____Addiction to alcohol or other drugs_____
_____Severe depression_____
_____Other significant mental illness or disorder_____
_____Genetic syndromes_____
_____Other_____

TRAUMA HISTORY

Has your child been verbally abused? __Y, __N, __Suspected. Specify: _____
_____

Has your child been physically abused? __Y, __N, __Suspected. Specify: _____
_____

Has your child been sexually abused? __Y, __N, __Suspected. Specify: _____
_____

Other stressors or traumas? _____
_____

Have you ever had any counseling before? ☐ Yes ☐No If yes please fill in the dates, diagnosis, which treated you.

DATE	DIAGNOSIS	PROVIDER

Has your child ever engaged in self harm acts? ☐ Yes: ☐ No If yes, method? _____

At what age did this begin?_____ Ever hospitalized for this? ☐ Yes: ☐ No

Has your child ever had suicidal thoughts? ☐ Yes: ☐ No Suicidal intensions? ☐ Yes: ☐ No

Has your child ever attempted suicide? ☐ Yes: ☐ No Age?____ Method? _____

Has your child ever had homicidal thoughts? ☐ Yes: ☐ No Homicidal intensions? ☐ Yes: ☐ No

Has your child ever attempted homicide? ☐ Yes: ☐ No Age?____ Method? _____

Child / Adolescent Information Form

SCHOOL HISTORY

Were you concerned about your child's ability to succeed in kindergarten? If so, explain:

_____

_____

To the best of your knowledge, is your child at, above, or below grade level in the following subjects:
Reading_____ Spelling_____ Math_____

Has your child ever had to repeat a grade? If so, when?_____
Present class placement: Regular class_____ Special class (Please specify)_____

_____

Has your child been evaluated at school for learning disabilities, emotional disturbance, academically? gifted, etc.? If so, when and with what results? _____

_____

Kinds of special counseling or remedial work your child is currently receiving:_____

_____

_____

Does your child's teacher describe any of the following as significant classroom problems:
Doesn't sit still in his/her seat_____
Frequently gets up and walks around the classroom_____
Shouts out. Doesn't wait to be called on_____
Won't wait his/her turn_____
Doesn't cooperate well in group activities_____
Typically does better in a one-to-one relationship_____
Doesn't respect the rights of others_____
Doesn't pay attention during group times_____
Struggles with forming friends _____
A pattern of not having homework done _____

Religious/Spiritual Background:

Do you have any significant religious or spiritual practices that are important to you? If so, briefly explain: _____

_____

Parent or Legal Guardian: _____ Date: _____

Counselor Signature: _____ Date: _____