

## Child/Adolescent Individual Form

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Child/Adolescent's Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Referred by: \_\_\_\_\_ Address: \_\_\_\_\_

Parent or Guardian Living with child/adolescent

Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Place of Business: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Spouse/Partner: \_\_\_\_\_

Occupation: \_\_\_\_\_ Place of Business: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Siblings (include biological, adopted, foster, step, etc.):

<u>Name:</u>	<u>Sex:</u>	<u>Age:</u>	<u>Type (bio, step, etc.):</u>	<u>Custody?</u>
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Is there any other person living in your household other than parents or siblings? Yes No  
If yes, please give their name/s and their relationship to you.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are biological parents divorced or separated?      Yes      No

If yes, for how long? \_\_\_\_\_

If parents are divorced provide name, address, and telephone number of biological parent not in household.

\_\_\_\_\_

Does non custodial parent share joint custody?    Yes      No

#### COUNSELING HISTORY OF CHILD/ADOLESCENT

From: \_\_\_\_\_ To: \_\_\_\_\_ With Whom? \_\_\_\_\_

For What? \_\_\_\_\_

BASIC HEALTH:     Good     Fair     Poor    Date of last Physical Exam? \_\_\_\_\_

Who is your Physician? \_\_\_\_\_

Is child/adolescent taking any prescription medication at this time?     Yes     No

If yes, what? \_\_\_\_\_

Is child/adolescent taking any over the counter medication?     Yes     No

If yes, What? \_\_\_\_\_

Is child/adolescent taking any medication for allergies?     Yes     No

If yes, What? \_\_\_\_\_

Are there any physical, emotional, or mental conditions now or in the past that I need to be aware of?     Yes     No

If yes, What? \_\_\_\_\_

Has child/adolescent ever been hospitalized?     Yes     No

If so, for What? \_\_\_\_\_

#### CURRENT REASON FOR SEEKING COUNSELING:

Briefly describe the problem for which you wish your child/adolescent to have counseling?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What would you like to see happen as a result of counseling?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The thing which concerns me the most right now is?

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IT IS CUSTOMARY TO PAY YOUR THERAPIST AFTER EACH SESSION.

\* A Counseling Session is normally \_\_\_\_ minutes.

POLICY

A \_\_\_\_-HOUR CANCELLATION NOTICE IS APPRECIATED; OTHERWISE USUAL FEE WILL BE CHARGED.

I understand that suicidal threats, homicidal threats or child abuse by an adult to a child will be reported.

I understand and give permission to my therapist to seek clinical supervision or consultation about my situation when necessary.

Parent's Signature \_\_\_\_\_

Adolescent's Signature \_\_\_\_\_