

To be completed by the child in cooperation with the parent/guardian. Please answer all questions. Use the back to explain any answer. You will have a chance to explain any answer as this will be used as a starting point in our first session.

Child Information Form

Name: _____ Today's date: _____
Nickname/Name you want to be called: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Birth Date: _____ Age: _____ Gender: _____

Living Arrangement

- Parents One Parent Different according to time Guardian

Parent's/Guardian's Names: _____

Where do you go to school? _____

Highest Grade Completed _____

Did you participate in the decision to start counseling? Yes No

Previous History

Please describe what brings you to counseling at this time.

What do you hope to gain through counseling?

What have you already done to deal with the difficulties?

Have you had previous psychological counseling or psychiatric help? Please check all that apply.

Individual counseling

If yes, when and where did you receive counseling and what were the issues:

Group Counseling

If yes, when/where issues:

Hospitalization(s)

If yes, when/where issues:

Current Life Experiences

My favorite thing to do to pass the time is _____

The person I am most likely to talk to about my problems is _____

I have many friends that I spend time with. Yes No

I feel alone a lot of the times. Yes No

A lot of the time I feel (circle one) angry sad guilty hurt frustrated

If you could, what's the one thing you would change about your life? _____

Please check any of the following you have experienced in the last 6 months.

- | | |
|---|--|
| <input type="checkbox"/> Sleep changes (more/less) | <input type="checkbox"/> Feeling Ignored or Abandoned |
| <input type="checkbox"/> Bad dreams/nightmares | <input type="checkbox"/> Thoughts of hurting self |
| <input type="checkbox"/> Appetite changes (more/less) | <input type="checkbox"/> Thoughts of hurting others |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Feelings of sadness/loss |
| <input type="checkbox"/> Weight problems | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Anxiety/tension/worry | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Fear of dying | <input type="checkbox"/> Fear of going "crazy" |
| <input type="checkbox"/> Anger/frustration | <input type="checkbox"/> Suspiciousness or mistrustfulness |
| <input type="checkbox"/> Problems trusting others | <input type="checkbox"/> Easily irritated/annoyed |
| <input type="checkbox"/> Aggressiveness | <input type="checkbox"/> Lying |
| <input type="checkbox"/> Making/keeping friends | <input type="checkbox"/> Arguing with others |
| <input type="checkbox"/> Self injurious behaviors | <input type="checkbox"/> Shyness |
| <input type="checkbox"/> Unpleasant thoughts that won't go away | <input type="checkbox"/> Bothered by recurring thoughts |
| <input type="checkbox"/> Destruction of property | <input type="checkbox"/> Use of alcohol |
| <input type="checkbox"/> Use of drugs | <input type="checkbox"/> Trouble with the law |

Please list all your current medications, dosage, and name of prescribing physician.

What else do you want me to know? _____
