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.):

Name:	Sex:	Age:	Type (bio, step, etc.):	Custody?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ 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?

_____

_____

_____

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 Type Full Name to Sign

Adolescent's Signature _____