Adolescent Information Form

Date: _____ (check one) New Client ____ Former Client: ___

Minor Name: _____ Date of Birth: _____

Guardian name(s):_____

Address: _____

Home phone:_____ Cell: _____

Email: _____

Mother's name: _____ Birth date: _____

Address (If different from Child) _____

Home phone: _____ Cell/pager: _____

Employer_____ Work phone_____

Father's (or partner's) name: _____ Birth date:_____

Address (if different) _____

Employer_____ Work phone_____

Emergency Contact Name (other than primary caregiver): _____

Relationship to Client: _____ Phone Number: _____

Parent's marital status: Married Divorced Separated Never married **Remarried:** Yes No How long? _____

Who has legal custody? Mom Dad Joint Other **Who has physical custody**? Mom Dad Joint Other
(Please provide proof of custody and decision making authority)

If there is DFACS involvement currently, please list case manager and contact number:
_____

Referral Source (How did you hear about us?): _____

Reason you are seeking treatment for your child:

Client's Name: _____

Symptom Checklist

(Please rate intensity and frequency)

Symptoms		Intensity			Frequency	When did symptoms begin?
☑		Mild	Moderate	Severe	(daily, 2x/ week)	
	Delusions					
	Hallucinations					
	Disorganized speech					
	Flat affect					
	Incoherent speech					
	Depressive symptoms					
	Oppositional					
	Disruptive					
	Attention deficit					
	Expressive language issues					
	Developmental delays					
	Receptive language issues					
	Sad most of the day					
	Hyperactive most of the day					
	Loss of interest					
	Significant weight loss/gain					
	Insomnia or hypersomnia					
	Feelings of worthlessness					
	Recurrent thoughts of death					
	Irritability; agitation					
	Mood disorders					
	Gang Involvement					
	Fire setting					
	Self-harm					
	Cruelty to animals					
	Violence to others					
	Excessive worry					
	Restlessness					
	Irritability					
	Easily fatigued					
	Difficulty concentrating					
	Sleep disturbance					
	Physical symptoms attributed to panic attacks					
	Destruction of property					
	Adjustment issues					
	Parent/child issues					
	Trauma/Abuse issues					
	Relationship issues					
	Eating disorders					
	Excessive Crying					
	Striking Others In Anger					
	Destroying Property in Anger					
	Frequent Fighting					
	Social Isolation					
	Criminal Involvement					
	Frequent Suspensions					
	Resistance to Authority					
	Obsessions					
	Impulsive behavior					
	Dissociates/Zones out					
	Other:					

Treatment service history (include history of suicidal/homicidal/aggressive behaviors. Also include if consumer is currently receiving services from another agency)

Treatment Received	Approximate Dates (MM/YY)	Service Provider	Outcome

Current Medical Problems:

Any known allergies:

Medications: including over the counter and vitamins, the prescribing provider, dosage, strength and frequency

Medication	Prescribing Doctor	Dosage	Frequency (twice daily, etc.)

Developmental History

Name of individual providing information: _____

Include information on prenatal, labor, delivery, neonatal, note any substance abuse, medication, illnesses, during the mother's pregnancy.

Physical growth and motor skills: Include any delays in walking, crawling, sitting up, concerns with height and weight; problems with coordination

Childhood illnesses or injuries:

Is there any history of a head injury? ____Yes ____No

If yes, please explain including whether there was a loss of consciousness, treatment, etc.

Describe social interactions. Include interactions with peers, siblings, adults, etc.

Educational/cognitive development: Include any concerns with reading, using words/sentences, attention deficit, concentration, and comprehension:

Has your adolescent ever used any of the following?

Drug	Started what age?	Currently using (Y/N)	How often?
Alcohol			
Marijuana			
Methamphetamines			
Cocaine			
Amphetamines (speed)			
Other:			

Does anyone in the home smoke cigarettes? _____ Yes _____ No

Current Living Situation

Home with biological parents		With non-custodial parent or guardian		Foster Home		Relatives	
With a friend		Shelter		Group Home		Homeless	

If not in a shelter or group home, list all others living in the home.

Name	Age	Relationship to Child	Quality of Interactions

Is there a non-custodial parent

_____ Yes _____ No

If so, describe the involvement on the part of that parent. Include info on visitation, child support, etc.

Family History of Mental Illness, Drug/Alcohol Abuse or Developmental Delays

Relative	Diagnosis/	Treatment/Services

Family's spiritual and cultural influences. Include religious influences, level of participation, etc.

Has the child ever experienced any of the following?

Event	Y or N	Event	Y or N
Death of a parent?		Been homeless or without necessities like food, water, heat?	
Death of a sibling?		Been the victim of a violent crime?	
Death of a child?		Been present when someone was physically assaulted, stabbed, shot, or killed?	
A close relative has a chronic illness?		Been in an accident in which someone was injured?	
Physical Abuse?		Suffered loss from a natural disaster (tornado, hurricane, flood, etc)	
Sexual Abuse?		Other distressing situation or event:	

School Life/Academics

Current school status. Name of school, grade level, attendance, and if not in school, include information on why. Also include if child receives special education services, has an IEP, behavioral plan or 504 plan.

Conduct issues. Include information on expulsions, suspensions, truancy, and other concerns.

Vocational Training/Experience (Complete only for adolescents who are 15 and older) Last employment, longest work period, type of work desired, future plans for employment beyond high school.

Legal Criminal History
List any arrests, convictions, probations. If currently on probation, list the name of the probation officer and contact number.

Interests/Activities: Include information on the client's daily schedule, leisure and recreational activities, interests, chores at home.

What are your child's strengths?

What do you like most about your child?

What are your hopes and goals for therapy?

_____ _____
Parent/Guardian Name (Please Print) **Date**

_____ _____
Parent/Guardian Signature **Date**

Licensed Clinician: _____ **Date:** _____
Signature