

*Counseling Associates for Well-Being*

**Child/Adolescent Information**

Please complete the following questions to the best of your ability. They are intended to assist us in providing the most informed care.

**Demographic Information**

Child's Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Gender: \_\_\_\_\_ Race: \_\_\_\_\_ Spiritual Preference: \_\_\_\_\_

**Parent/Guardian Contact Information**

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

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell or Other: \_\_\_\_\_

May we leave a message? YES \_\_\_\_\_ NO \_\_\_\_\_ What is the best time to reach you? \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Briefly describe the main reason that you brought your child here for care: \_\_\_\_\_

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

Referred by: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_

May we contact them to thank them for the referral? Y N

**School Information**

School Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Teacher(s)' Name(s): \_\_\_\_\_

Has your child met with a school counselor or social worker? Y N If yes, what is his/her name: \_\_\_\_\_

\_\_\_\_\_

Would you like to sign a release of information allowing your child's therapist to contact the school for treatment planning purposes? \_\_\_\_\_

**Family Information**

Please list all parents/guardians:

Name

Age

Occupation

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Number of child's siblings? \_\_\_\_\_

Please list their names and ages: \_\_\_\_\_

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Do any blood relatives of the child have any mental health or substance abuse problems? \_\_\_\_\_

Please describe: \_\_\_\_\_

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### **Health Information**

Please provide the name, address and, phone number of your child's Primary Care Physician (if he/she has one):

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

Address \_\_\_\_\_

Phone: \_\_\_\_\_

Please list any medical problems or conditions for which your child is currently being treated: \_\_\_\_\_

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Please list any medications which your child is currently taking, including any herbal or over the counter medicines: \_\_\_\_\_

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Please list any medications your child has taken in the past that were prescribed to alleviate mental health symptoms: \_\_\_\_\_

Has your child previously received any counseling, psychotherapy or psychiatric care? \_\_\_\_\_

Please describe (when, what kind, by whom): \_\_\_\_\_

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**Personal Information**

Name three words to describe your child: \_\_\_\_\_

Name three words to describe your parenting style: \_\_\_\_\_

Has your child ever been physically, emotionally, or sexually abused by anyone? Please briefly describe as much as you are comfortable: \_\_\_\_\_

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

Please describe any legal issues (for example custody, DJJ involvement) your child is currently or has previously been involved in: \_\_\_\_\_

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

Please describe your child's use of alcohol and/or drugs: \_\_\_\_\_

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

Do you consider your child to have a healthy relationship with food? \_\_\_\_\_

Describe: \_\_\_\_\_

\_\_\_\_\_

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**THIS SECTION FOR OFFICE USE ONLY**

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DSMIV DX:

Axis I: \_\_\_\_\_

AxisII: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

Axis V: \_\_\_\_\_

NOTES: \_\_\_\_\_

**CHILD and ADOLESCENT ADDENDUM TO THE  
CLINICAL ASSESSMENT**

**PRENATAL, PERINATAL AND DEVELOPMENTAL EVENTS and HISTORY**

• **PREGNANCY**

- Normal and routine
- Problematic \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

• **FETAL HEALTH prior to birth** Include child's exposure to substances during gestational development: amounts, frequency and duration

- Alcohol \_\_\_\_\_
- Illicit drugs \_\_\_\_\_
- Prescriptive medications \_\_\_\_\_
- Tobacco \_\_\_\_\_
- Caffeine \_\_\_\_\_

• **GESTATION:** Born at \_\_\_\_\_ weeks. Came home at \_\_\_\_\_ weeks.

• **BIRTH**

- Routine delivery**       Without complication
- With complications \_\_\_\_\_

- Cesarean delivery**       Without complication
- With complications \_\_\_\_\_

• **DEVELOPMENTAL HISTORY AND MILETONES**

	Within Normal Limits	<u>Notes-(Grades, relationship with siblings, daycare, discipline)</u>
Sat up	<input type="checkbox"/>	_____
Pulled UP	<input type="checkbox"/>	_____
Walked	<input type="checkbox"/>	_____
Off Bottle	<input type="checkbox"/>	_____
Used Cup	<input type="checkbox"/>	_____
Fed self	<input type="checkbox"/>	_____
Toilet Training	<input type="checkbox"/>	_____
Spoke first word	<input type="checkbox"/>	_____
Spoke in Sentences	<input type="checkbox"/>	_____
Acclimated/transitioned to school	<input type="checkbox"/>	_____

• **PARENTAL CONCERNS OF NOTE** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Completing this brief questionnaire will help us provide services that meet your child's needs. Answer each question as best you can and then review your responses with your child's clinician. Shade circles like this ●

Child's Last Name												First Name												Child's Date of Birth: (mm/dd/yy)					
Subscriber ID												Authorization #																	

Clinician Last Name												First Name												Today's Date: (mm/dd/yy)					
Clinician ID/Tax ID												Clinician Phone												State					

Visit #: <input type="radio"/> 1 or 2 <input type="radio"/> 3 to 5 <input type="radio"/> Other												Relationship to child: <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Stepparent <input type="radio"/> Other Relative <input type="radio"/> Child/Self <input type="radio"/> Other											
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*For questions 1-21, please think about your experience in the past week.*

**Fill in the circle that best describes your child:**

	<i>Never</i>	<i>Sometimes</i>	<i>Often</i>
1. Destroyed property	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Was unhappy or sad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Behavior caused school problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Had temper outbursts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Worrying prevented him/her from doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Felt worthless or inferior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Had trouble sleeping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Changed moods quickly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Used alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Was restless, trouble staying seated	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Engaged in repetitious behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Used drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Worried about most everything	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Needed constant attention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**How much have your child's problems caused:**

	<i>Not at All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>A Lot</i>
15. Interruption of personal time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Disruption of family routines?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Any family member to suffer mental or physical problems?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. Less attention paid to any family member?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. Disruption or upset of relationships within the family?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. Disruption or upset of your family's social activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. How many days in the past week was your child's usual routine interrupted by their problems?				<input type="text"/> Days

**Answer the following only if this is your first time completing this questionnaire for this child.**

- 22. In general, would you say your child's health is:  Excellent  Very Good  Good  Fair  Poor
- 23. In the past 6 months, how many times did your child visit a medical doctor?  None  1  2-3  4-5  6+
- 24. In past month, how many days were you unable to work because of your child's problems?  Days  
*(answer only if employed)*
- 25. In the past month, how many days were you able to work but had to cut back on how much you got done because of your child's problems?  Days  
*(answer only if employed)*