CHILD/ADOLESCENT PACKET **(to be completed by parent/guardian)**

ACCESS CHRISTIAN COUNSELING

PERSONAL HISTORY INFORMATION

Welcome to Access Christian Counseling!

The purpose of this form is to gain a better understanding of your background and presenting issues. Please note that this information is confidential and, within all legal limits, will not be shared with others.

Child/Adolescent Name: _____

Address: _____

City: _____ Zip Code: _____

Home Phone #: _____ Cell Phone#: _____

May we leave a message at these #s? Y N E-Mail Address: _____

Age: _____ Client's Date of Birth: _____

How were you referred to Access? _____

Mother's: name/address/city/zip: _____

Home #: _____ Work #: _____ Cell #: _____

Father's: name/address/city/zip:_____

Home #: _____ Work #: _____ Cell #: _____

Legal Guardian's: name/address/city/zip:_____

Home #: _____ Work #: _____ Cell #: _____

Driver's License #: _____

TREATMENT INFORMATION

Person completing form: _____

Relationship to child/adolescent: _____

Reason child/adolescent is coming for treatment: _____

_____

Has your child/adolescent ever received treatment before? ____ Yes ____ No (If yes, please explain…) _____

How does your child/adolescent feel about treatment at this time? _____

_____

What would you like to have happen while your child/adolescent is in treatment here?

_____

If needed, are you willing to participate in services that would help in your child's/adolescent's treatment? _____

SCHOOL ADJUSTMENT

Name of School: _____ Home Room Teacher's name: _____

Address and Phone #: _____

Grade: _____ Has s/he ever repeated a grade and if so, which one? _____

What sort of grades is your child/adolescent receiving? _____

Please describe any difficulties your child/adolescent is experiencing in school _____

_____

_____

How would you describe his/her intellectual functioning? ____ Good ____ Fair ___ Poor

Has your child/adolescent ever been psychologically tested? ____ Yes ____ No If yes, When? _____ Where? _____

Has your child/adolescent ever had special education? ____ Yes ____ No If yes, please explain _____

PERSONAL ADJUSTMENT

Please check any of the following that are typical of your child/adolescent's behavior:

___ Shy
___ Worries
___ Moody
___ Sad, cries
___ Loner
___ Expects failure
___ Selfish
___ Lazy
___ Avoids conflict
___ Sexual acting out
___ Police problems
___ Tics or twitch
___ Easygoing
___ Friendly
___ Enthusiastic
___ Confident
___ Acts without thinking
___ Clumsy
___ Suicide attempt
___ Angry, Defiant
___ Quarrels
___ Bullies
___ Temper tantrums
___ Lies frequently
___ Destructive
___ Steals
___ Sets fires
___ Drug/alcohol use
___ Frequent headaches
___ Stomach aches
___ Messy
___ Careless, reckless
___ Short attention span
___ Frequent daydreams
___ Overactive
___ Sloppy hygiene
___ frequent injuries
___ Psychiatric problems
___ Slow moving
___ Difficult sleep
___ Sleepwalking
___ Bedwetting
___ Soiling
___ Poor appetite
___ Weight loss
___ Overweight
___ Often ill
___ Unusual thinking
___ Bizarre behavior
___ Blinking, jerking
___ Seizures
___ Speech problems
___ Learning problems
___ Cooperative
___ Generous
___ Suicide gestures

Explain any of the above _____
_____
_____

LEGAL

Has the child/adolescent ever been involved with the police or juvenile court system?
____ Yes ___ No If yes, please explain _____
_____

Are both parents in agreement with bringing s/he into treatment? ____ Yes ____ No
If no, please explain _____

Are the parents currently involved in a divorce or custody issue? ____ Yes ____ No
If yes, please explain _____

Are the parents still married? ____ Yes ____ No If no, who has physical custody of the Child/adolescent? _____ Who has legal custody? _____

A copy of the custody agreement is on file at Access. ___Yes ___No (required)

CHILD'S/ADOLESCENT'S FAMILY

Is your child's/adolescent's immunization current? ____ Yes ____ No

	Name	Age	Sex	Education/Employment	Marital Status
Father					
Mother					
Siblings					
Others in home					

SOCIAL HISTORY

How does your child relate to peers? _____

Has your child/adolescent ever worked? _____

Describe how s/he relates to people (e.g. easily, shy, leader, follower): _____
_____

With whom does your child socialize? _____

Does your child/adolescent isolate him or herself from others? ____ Yes ____ No If yes, please explain _____

RELIGION

Does the family have a religion? ____ Yes ____ No If yes, what? _____

Does the child/adolescent practice? ____ Yes ____ No Denomination? _____

CULTURAL/ETHNIC INFORMATION

What culture or ethnic group do s/he come from? _____

Do s/he closely identify with this group? _____

What strengths has your child/adolescent acquired from this identity?

_____

SUBSTANCE ABUSE HISTORY

Does the child/adolescent have a problem with alcohol or drugs? ____ Yes ____ No

If yes, please explain _____

Has the child/adolescent ever received substance abuse treatment? ____ Yes ____ No

If yes, please explain _____

Is there a family history of substance abuse? ____ Yes ____ No

If yes, please explain _____

OTHER INFORMATION THAT WOULD BE HELPFUL ABOUT YOUR CHILD/ ADOLESCENT _____

_____

_____

DEVELOPMENTAL HISTORY (check all that apply)

During pregnancy: Any bleeding? ____ High blood pressure? ____Weight gained? ____

Check any that were used during pregnancy: ____ Tobacco ____ Alcohol ____ Drugs

Please explain _____

Sickness of the mother? _____

Other difficulties? _____

Birth: ____ Full Term ____ Premature Weight _____ Length of labor _____

Type of delivery: (e.g., breech, cesarean, normal) _____

Condition at birth? _____

Was oxygen given at birth? _____

At what age did your child: Walk alone? ____ Use single words? ____ Sentences? ___ Toilet train? ____

Has your child/adolescent had an eye exam? ____ Yes ____ No Results: _____

Has your child/adolescent had a hearing exam? ____ Yes ____ No Results: _____

Has your child/adolescent ever had difficulties regarding speech functioning? ____ Yes ____ No If yes, please explain _____

Has your child/adolescent ever had convulsions? ____ Yes ____ No If yes, please explain _____

Has your s/he ever experienced injuries, hospitalizations? ____ Yes ____ No If yes, please explain _____

Was your child/adolescent adopted? ____ Yes ____ No If yes, at what age? _____

Does your child know about his/her adoption? ____ Yes ____ No

For girls only: Age at onset of menstrual period: _____ Problems? _____ Pregnancies? ____ Yes ____ No Abortions? ____ Yes ____ No If yes, number of abortions? _____

CHILD'S/ADOLESCENT'S PHYSICIAN

Name: _____ Phone # _____

Address: _____

Date of child's/adolescent's last physical exam? _____ Results: _____

_____

Is the child taking any medication? ____ Yes ____ No If yes, which medication?

_____

Has either parent ever been separated from the child/adolescent? ____ Yes ____ No If yes, please describe _____

********** ***Office Use Only***

_____ Date _____

Therapist's signature and credentials