



Child and Adolescent Information Form

This form is to be completed by the parent/ legal guardian requesting services for a minor child. This information will help your therapist to better understand your child and his/her needs. This, as well as other communications with your therapist, will be kept confidential to the full extent of Georgia law.

Child's name _____ Date of Birth _____ Age _____

Name of person completing this form _____

I declare that I am the custodial parent or legal guardian of the child described in the document and that I have the legal authority to request and consent to his/her psychological treatment.

Signature _____ Date _____

Were you referred for consultation by another professional? Y or N

If yes, referral source _____

If you would like for your therapist to contact your referring professional to coordinate treatment, you will need to fill out a "Release of Information" form to give permission.

Current concerns

Why are you bringing your child for treatment? *(What behaviors, feelings, thoughts, or problems are causing you to be concerned about your child?)*

What are your goals in coming here? *(What kinds of changes do you want to make, or how do you want things to be different for your child and/or your family?)*



Demographics

The child is living with:

- birth parent(s)
- foster parent(s)
- adoptive parent(s)
- with other relative(s)
- in a residential center

Are the child's parent(s):

- Married/ living together
- Divorced
- Single
- Separated
- Widowed

Child's siblings:

Name _____ Age _____
Living in same home as child? Yes or No or Sometimes

Name _____ Age _____
Living in same home as child? Yes or No or Sometimes

Name _____ Age _____
Living in same home as child? Yes or No or Sometimes

Name _____ Age _____
Living in same home as child? Yes or No or Sometimes

Who else lives in the home? _____

Areas of Concern

Please place a check next to each problem or symptom that is currently a concern for your child:

- Anxiety/worry
- Grief from the loss of an important person
- Fearfulness/phobias Feeling unhappy a lot of the time
- Clingy or overly dependent
- Depression
- Nervous habits (such as nail biting) Thoughts of suicide
- Obsessive thoughts
- Self-harming behaviors



- Compulsive behavior
- Academic problems or educational concerns
- Emotional sensitivity
- Difficulty calming down when upset
- Conflict with siblings
- Anger/ temper
- Conflict with parents
- Aggressive or destructive behavior
- Stress from parent conflict or separation
- Problems with accepting discipline
- Stress from other problems in the family
- Stealing
- Insecure/ timid/ lack of self-confidence
- Frequent lying
- Low self-esteem
- Rigid thinking or stubborn behavior ☑ Loneliness
- Difficulty with change or transitions
- Friendship problems
- Unusual or repetitive behaviors
- Religious or spiritual concerns
- Impulsive behavior
- Stress from physical or health concerns
- Loud, silly, or inappropriate behavior
- Acts immature for age
- Use of alcohol or other drugs
- Very disorganized or messy
- Legal problems
- Takes too long to get through tasks
- Traumatic stress
- Forgetful
- Unsafe or risky behavior
- Short attention span
- Other _____

Recent changes or stressful circumstances

- Have there been any recent deaths in the family?
- Has a parent recently married or divorced?
- Have any new children been adopted or born or come to live with the family?
- Has a parent been separated from the family for a long period of time (such as from deployment, incarceration, or moving for work)?
- Has the child's residence recently changed?
- Has the child had a disruption in an important friendship or other relationship?
- Has the child witnessed stress in the family from a sibling's problems?
- Has the child been seriously ill or hospitalized?
- Has the child's parent or family member been seriously ill or hospitalized?
- Has a family member had recent legal problems?
- Has a family member had emotional, mental health, or substance use problems?
- Has the child had serious school problems?



- Has the child been under stress from having a lot of activities or responsibilities?
- Has the child had a very disappointing experience with an extracurricular activity, sports team, youth group, etc.?
- Has the child become involved with alcohol or drugs?
- Have there been a lot of arguments or conflicts at home?
- Has a parent recently lost a job or had a change in financial status?
- Has the family been in financial difficulty or had inadequate income, inadequate health care, inadequate or unsafe living situations, or frequent worry about these?
- Has the child recently become sexually active?
- Has the child witnessed verbal altercations, threatening behavior, physical violence, sexual behavior, or a scary situation (such as a car accident)?
- Has the child personally experienced verbal threats, threatening behavior, physical violence, sexual molestation, or a scary situation (such as a car accident)?
- Has the child or a family member been a victim of a crime?
- Has the child or a family member experienced a fire, flood, tornado, hurricane, or other natural disaster?
- Has the child or a family member experienced conditions such as a war, riot, assault, or other event involving or threatening physical harm?

If you checked any of the questions about stressful circumstances, please explain briefly:

Health History

Has your child ever received any previous mental health treatment (therapy or psychiatric medication from a counselor, psychologist, psychiatrist, or pediatrician)? Yes or No

If yes, please list:

Name	Location	Phone number	When



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Please list your child's current medications (if applicable):

Name of medication	Dosage	When did the child start taking it?	What is the medication for?	Who prescribes it?

Does your child receive any supplements, herbal medicines, or alternative therapies? Yes or No

If yes, please describe: _____

Has your child received any previous neurological evaluations, medical imaging, lab tests, neuropsychological assessments or psychological evaluations? Yes or No

If yes, please describe: _____

Does your child have any history of serious illness, injury, concussions, car accidents, hospitalizations, or operations? Yes or No

Does your child have any current or chronic medical conditions or disorders? Yes or No

Does your child have any problems with vision? Yes or No Does your child have any problems with hearing or speech? Yes or No



Does your child have any problems with motor skills or with being awkward or clumsy? Yes or No

Does your child have any allergies or sensitivities to drugs, food or other substances? Yes or No

If yes to any of the above, please describe the problem(s) and any treatment received

To your knowledge, has your child used... (Check all that apply):

- Cigarettes
- Narcotics
- Cocaine
- Other forms of tobacco
- Steroids
- Heroin
- Caffeine
- Marijuana
- Hallucinogens
- Alcohol
- Non-prescribed stimulants
- Other recreational drugs
- Non-prescribed painkillers
- Methamphetamine

What best describes your child's sleep? (Check all that apply):

- Has no sleep problems
- Wakes frequently at night
- Sleeps too much
- Has irregular sleep patterns
- Doesn't sleep enough
- Has nightmares or night terrors
- Has problems falling asleep
- Has nighttime bed-wetting
- Wakes too early
- Sleeps with parents or siblings

What best describes your child's activity level and exercise habits? (check all that apply)

- Has a low energy level
- Exercises/plays outside most days
- Prefers quiet or seated activities



- Has a high activity level
- Rarely gets exercise
- Is constantly moving
- Has a moderate activity level
- Needs a lot of vigorous exercise in order to
- Exercises/ plays outside a few times a week relax or sleep well

What best describes your child's eating patterns? (check all that apply)

- Has a healthy appetite
- Eats too much
- Eats too much junk food
- Appetite varies a lot
- Seems obsessed with food
- Is a picky eater
- Eats too little
- Eats a variety of foods

Who in the child's family has a history of: (circle all that apply)

- Depression: mother | father | sibling | mother's relative | father's relative
- Bipolar disorder: mother | father | sibling | mother's relative | father's relative
- Anxiety disorder: mother | father | sibling | mother's relative | father's relative
- Obsessive-compulsive: mother | father | sibling | mother's relative | father's relative
- Phobias: mother | father | sibling | mother's relative | father's relative
- Psychotic disorder: mother | father | sibling | mother's relative | father's relative
- Autism or Asperger's: mother | father | sibling | mother's relative | father's relative
- Attention disorder: mother | father | sibling | mother's relative | father's relative
- Learning disorder: mother | father | sibling | mother's relative | father's relative
- Intellectual disorder: mother | father | sibling | mother's relative | father's relative
- Substance abuse: mother | father | sibling | mother's relative | father's relative
- Gambling/sexual addiction: mother | father | sibling | mother's relative | father's relative
- Anger control problems: mother | father | sibling | mother's relative | father's relative
- Eating disorder: mother | father | sibling | mother's relative | father's relative
- Personality disorder: mother | father | sibling | mother's relative | father's relative



Developmental History

Did your child have any problems during birth or any health problems as an infant? Yes or No

If yes, please describe_____

Was your child exposed to any alcohol, medications, cigarettes, or toxins before birth? Yes or No

If yes, please describe_____

Did your child babble and smile at other people by 4 months? Yes or No

Did your child sit without support by 9 months? Yes or No

Did your child crawl by 9 months? Yes or No

Did your child say at least one word by 12 months? Yes or No

Did your child walk independently by 18 months? Yes or No

Did your child say two-word sentences by 2 years? Yes or No

Did your child follow simple instructions by 2 years? Yes or No

Was your child toilet-trained by 3 years? Yes or No

Has your child ever experienced circumstances of neglect or inadequate care? Yes or No

Who were the child's primary caretaker(s) during the first five years?

Which best describe your child's temperament during the first five years? (check all that apply)

- Usually cheerful or easy-going
- Eager or bold in new situations
- Frequently irritable/ fussy
- Generally calm or even-tempered
- Usually played quietly
- Easily excitable or intense in reactions
- Moderately active
- Very sensitive to noise, lights, stimulation
- Very busy
- Able to tolerate stimulation easily



- Adaptable
- Concentrated well
- Difficulty adjusting to changes
- Easily distracted
- Kept to a fairly regular schedule
- Persisted when frustrated
- Irregular in daily schedule
- Gave up easily

- Cautious in new situations

Which best describes your child when interacting with other children/adolescents? (check all that apply)

- Is interested in playing with other children
- Has at least a few preferred friends
- Has little interest in playing with others
- Doesn't really have close friends
- Is sociable and outgoing
- Has trouble joining a group
- Is shy
- Doesn't seem to understand social rules
- Needs time to get used to new children
- Usually is a leader
- Prefers to play alone
- Usually is a follower
- Can play independently
- Often is too bossy
- Has difficulty playing independently
- Has trouble standing up for herself/himself
- Gets along well with other children
- Gets feelings hurt easily with friends
- Has difficulty getting along with others
- Gets along better with adults than children
- Says "I don't have any friends"
- Other _____

What extra-curricular activities or organizations is your child involved in?

Does your child attend a church, synagogue, mosque, or other spiritual or religious center?

What are your child's interests, hobbies, or preferred activities?

What are your child's daily/weekly responsibilities or chores?



What are the rules and behavioral expectations in the family for your child?

What type of behavioral guidance and discipline strategies do you use in your family?

Please describe the child's relationship with each parent:

Please describe the child's relationship with his/ her sibling(s) (if applicable):

Academic History

Please list the child's current school, grade, and teachers (*if your child is in middle school or high school, list one or two teachers who know your child well*):

Does your child like school?

All or most of the time Sometimes Almost never

Your child's grades are currently:

- Excellent/ As and Bs
- Satisfactory/ Cs and Ds
- Good/ Bs and Cs
- Unsatisfactory/ Ds and Fs

In the past year, how much school has your child missed because of illness, injury or other reasons?

- Less than 2 weeks
- 5 weeks to 8 weeks
- 2 weeks to 4 weeks
- More than 8 weeks



Has your child ever received (Check all that apply):

- "Babies Can't Wait" services
- "Collaborative" classroom placement
- Head Start services Resource room/ small group instruction
- Early Intervention services
- Exceptional children's services or IEP
- Speech therapy at school Student assistance services (C.A.R.E.)
- Occupational therapy at school

Has your child ever repeated a grade? Yes or No If so, which grade(s)? _____

In primary grades (Kindergarten – 2nd), did your child have... (Check all that apply):

- No academic, social, or school adjustment concerns
- Academic or learning problems
- Problems completing homework
- Problems with adjusting to school, classroom routines or teacher(s)
- Social difficulties

Please describe any difficulties _____

In elementary grades (3rd – 5th), did your child have... (Check all that apply):

- No academic, social, or school adjustment concerns
- Academic or learning problems
- Problems completing homework
- Problems with adjusting to school, classroom routines or teacher(s)
- Social difficulties

Please describe any difficulties _____

In middle school, did your child have.... (Check all that apply):

- No academic, social, or school adjustment concerns
- Academic or learning problems
- Problems completing homework
- Problems with adjusting to school, classroom routines or teacher(s)
- Social difficulties

Please describe any difficulties _____

In high school, did your child have... (Check all that apply):

- No academic, social, or school adjustment concerns
- Academic or learning problems
- Problems completing homework
- Problems with adjusting to school, classroom routines or teacher(s)
- Social difficulties

Please describe any difficulties _____

Please note any additional information you would like your therapist to know.
