Child and Adolescent Information Form

Today's Date _____ DOB: _____ Gender _____ Referral Source _____

Name: _____
Last First Middle (Nickname)

Address: _____ Phone: _____

Current School: _____ Grade: _____ Alternate Phone: _____

Emergency Contact: _____ (name, relationship) Phone: _____

Family Composition:

Name	Age	Relationship to Child	Occupation and/or Location (if not home)

Youth's strengths: (what is he/she good at, in what areas does he/she excel, when does he/she succeed?)

_____

_____

_____

Family's strengths and/or strengths as a parent: _____

_____

_____

Area where parent struggles the most in terms of parenting effectively? _____

_____

_____

How would you rate your relationship? (parent and child) _____

_____

Presenting Issues: _____

_____

_____

_____

When is the presenting issue NOT a problem (for example, using the "Exception question" – when DOES Johnny handle his anger appropriately?)

_____

_____

_____

What strategies have been tried in the past? How successful were they? _____

_____

_____

History of previous treatment? (counseling, psychiatric evaluations, hospitalizations, drug/alcohol treatment, medications) Include location and dates. _____

_____

_____

Diagnosis history _____(WHO diagnosed and when)

Current Medications ____ None _____

How long have you taken these meds?_____ Last use _____ Rx by _____

Major medical problems, surgery, accident, or illness (that impact current functioning)? None

_____

Suicidal or homicidal ideation, thoughts, attempts? None (include dates, method, and outcomes)
**** If there is current SI/HI, implement safety plan immediately before leaving the home and leave copy with family.

_____

_____

Eating or sleeping problems in the last 30 days? None _____

Nightmares, (auditory or visual) hallucinations, or self-mutilation behaviors? None _____

_____

Who else is *currently* involved_____
(include CMO, YCM, residential, shelter, Dr., therapist)

Legal Issues: _____

Upcoming Court Dates: _____

Recommendations/Goals for Treatment: _____

_____

_____

_____

Client Signature _____ Date: _____

Parent Signature _____ Date: _____

Therapist's Signature _____ Date: _____

Problem Checklist for Children and Adolescents

(Must be completed at intake session and at discharge)

Name _____ Date _____

(****** NOTE: Please distinguish between parent/guardian's answers and youth's answers. For example, note one with a triangle, and one with a circle. It is often helpful to go over this list with parent and child SEPARATELY but note the disparity between child's answers and parent's.)

List represents common difficulties or concerns that individuals may have. Please read the list and rate the severity of each item by circling one number for each item. If the item is not a problem, circle "0."

	Not a Problem	Occasional Problem	Mild Problem	Moderate Problem	Severe Problem
School Problems (behavioral)	0	1	2	3	4
Learning Disability/Academic	0	1	2	3	4
Rebellious Behavior	0	1	2	3	4
Hyperactivity/Can't slow down	0	1	2	3	4
Attention/Concentration problems	0	1	2	3	4
Eating Problems (appetite, gorging)	0	1	2	3	4
Nervous Tics/Movements	0	1	2	3	4
Has Bladder/Bowel accidents	0	1	2	3	4
Problems w/Parents	0	1	2	3	4
Problems w/other family members	0	1	2	3	4
Physical Health problems	0	1	2	3	4
Traumatic Experience (s)	0	1	2	3	4
Legal Problems	0	1	2	3	4
Confusion or memory problems	0	1	2	3	4
Disturbing thoughts or dreams	0	1	2	3	4
Lack of confidence/low self- esteem	0	1	2	3	4
Feelings of depression or sadness	0	1	2	3	4
Feelings of nervousness/worry	0	1	2	3	4
Impulse control problems/decisions	0	1	2	3	4
Irritability or impatience	0	1	2	3	4
Feelings of guilt	0	1	2	3	4

	Not a Problem	Occasional Problem	Mild Problem	Moderate Problem	Severe Problem
Loneliness and or social withdrawal	0	1	2	3	4
Problems accepting authority	0	1	2	3	4
Problems with grief	0	1	2	3	4
Trouble relating to others	0	1	2	3	4
Sexual concerns/promiscuity	0	1	2	3	4
Alcohol or drug abuse	0	1	2	3	4
Sleep problems	0	1	2	3	4
Anger or problems w/temper	0	1	2	3	4
Fears/Phobias	0	1	2	3	4
Separation or divorce	0	1	2	3	4
Lies or Exaggerates	0	1	2	3	4
Childish or immature	0	1	2	3	4
Runs Away	0	1	2	3	4
Steals Things	0	1	2	3	4
Basic Needs clothing, food, housing	0	1	2	3	4

The following issues need further documentation or follow up if marked more than "0"

*Sexual Abuse	0	1	2	3	4
*Fire Setting	0	1	2	3	4
*Gang Involvement	0	1	2	3	4
*Suicidal/homicidal ideation	0	1	2	3	4

Explanation/Clarification of any of the above four issues: _____

_____

_____

Client Signature _____ Parent Signature_____

If not completed by client, reason? _____

Intake Score_____ Final Score_____

Authorization to Release Information

I, _____, hereby authorize _____ to release/obtain information contained in my client records to/from the following individual(s) and/or organization(s), and only under the conditions listed below.

Name of person(s), organization(s) and address/phone to whom disclosure/exchange is to be made:

_____

_____

The purpose and need for such disclosure/exchange: (Check all that apply)

Continuity of treatment _____ Family Involvement ____

After Care Planning _____ Referral _____

Other: (Please Specify) _____

This consent is subject to revocation at any time. This consent will terminate within one year of signing.

Client Signature_____ Date_____

Parent Signature_____ Date_____

Witness Signature_____ Date_____