CHILD Information Gathering Form

Age 9 through 18

To save valuable session time, please print off and complete this form. Answer the questions to the best of your knowledge. If there are any questions that make you uncomfortable or unsure about, simply skip it. Use back side if more space is needed to answer question. **The information you provide is confidential and will not be shared. PLEASE PRINT. THANK YOU.**

Name: _____
Last First Middle

Home Address: _____ City & State: _____ Zip: _____

Date of Birth: ____/____/_____ Age: _____ SSN: _____- _____ - _____

Gender: ___ Female ___ Male Gender Identification: ___ Female ___ Male ___ Other

School: _____ Grade: _____ Performance: _____

Attitude about school & why: _____

_____

Extracurricular Activities: _____

_____

Parent or Guardian Information:

Mother's Name_____ Date of Birth: _____

Home Address: _____ Zip: _____

Phones: Home _____ OK to leave message ____ YES _____ NO

Cell: _____ OK to leave message ____ YES _____ NO

Preferred Email: _____ May we email you? ___ Y ___ N

NOTE: Email is not a 'secure and confidential' form of communication.

Employed ___ Y ___ N Occupation: _____ Length Employed: _____

Work Phone: _____ May we leave a message? ___ Y ___ N

Work Email: _____ May we email you? ___ Y ___ N

NOTE: Email is not a 'secure and confidential' form of communication.

Father's Name_____ Date of Birth: _____

Employed ___ Y ___ N Occupation: _____ Length Employed: _____

Work Phone: _____ May we leave a message? ___ Y ___ N

Work Email: _____ May we email you? ___ Y ___ N

NOTE: Email is not a 'secure and confidential' form of communication.

Home Address: _____ Zip: _____

(only if different from Mother's)

Phones: Home _____ OK to leave message ____ YES _____ NO

Cell: _____ OK to leave message ____ YES _____ NO

Preferred Email: _____ May we email you? ___ Y ___ N

NOTE: Email is not a 'secure and confidential' form of communication.

Emergency Contact Individual:

Name: _____ Relationship: _____ Phone # _____
Permission to contact this individual ____ YES ____ NO

FINANCIALLY RESPONSIBLE PARTY: (If same as a guardian above, state who & complete info not requested above.)

First Name: _____ Last: _____ Relationship: _____

Social Security #: _____ Date of Birth: _____

Address: _____ Zip: _____

Preferred Phone: _____ OK to leave message ____ YES _____ NO

Alternate: _____ OK to leave message ____ YES _____ NO

NOTE: In questions to follow you may be asked to rate something on a scale of 1-10, please rate according to the following: Mild Moderate Severe **(Severe may indicate need for hospitalization.)**

1 2 3 4 5 6 7 8 9 10

Reason for Seeking Counseling

What it is that brings you to seek counseling for your child at this specific time in their life?

_____

_____

_____

How long has this been a problem? _____ Pls rate severity on 1---10 scale _____

How have you dealt with this in the past and how did that work?

_____

_____

_____

_____

Is there anything that you recognize as making the problem / issue worse at specific times?

_____

_____

_____

What are specific changes you want to achieve with counseling? (if not sure, may require discussion with therapist)

_____

_____

_____ How long do you think it should take? _____

Recent significant changes or stressful events in your child's life: _____

_____

Past (more than 2 yrs) significant changes or stressful events in your child's life: _____

_____

General Health Information

1. Has your child ever received mental health services in the past? (Counseling, psychotherapy, psychiatric services, in-patient or out-patient substance abuse) __ Y __ N If Yes, Type: _____

If yes, Please specify When: _____ How Long: _____ Why: _____

Where or with whom: _____

May we contact them for information? ___ Y ___ N Contact Phone: _____

2. Child's Physician: _____ Phone: _____

May we have permission to contact physician if we believe it is needed? _____ YES _____ NO

Last appt: _____ If Female, has period begun: _____ At what age: _____

3. Is your child taking any prescription medications or over-the-counter? If so, Please provide information:

Name of medication	Dosage & x's per day	When began	Purpose

4. How would you rate your child's current physical health? (check most appropriate)

___ Poor ___ Unsatisfactory ___ Satisfactory ___ Good ___ Very Good ___ Excellent

What accounts for the rating you selected? _____

5. Please list any specific or chronic health problems (including pain) they have been experiencing, if any.

_____

What is being done to deal with the problem? _____

6. Please rate your child's current sleeping habits:

___ Poor ___ Unsatisfactory ___ Satisfactory ___ Good ___ Very Good ___ Excellent

What accounts for the rating you selected? _____

7. How many times (if at all) does your child exercise in a week? _____

Average length of time: _____ Since When? _____ Rate their enjoyment of exercise, 1-10 : _____

What type of exercise do they engage in: _____

8. What meals does your child typically eat on a daily basis and approximate time of day eaten?

___ breakfast _____am or pm / ___ lunch _____ am or pm / ___ dinner _____ am or pm

___ snacks ____ times a day ~ Most during ___ day ___ night Types: _____

Mental Health Information

Please rate on 10 point scale any symptoms that your child may be having (to the best of your knowledge):

Depression		Feeling Hopeless		Worrying a lot	
Extreme sadness		Feeling tearful		Isolating	
Trouble concentrating		Feeling stressed		Mood swings	
Memory problems		Lack of energy		Excess energy	
Change in eating habits		Weight Loss		Weight Loss	
Lack of enjoyment of activities		Feelings of extreme happiness		Blaming others	

Problems with friends or family		Poor decisions		Weight gain	
Self-esteem problems		Easily irritated		Poor impulse control	
Perfectionism		Feeling guilty		Hurting animals	
Obsessions or compulsions		Feeling nervous or anxious		Drug / alcohol Use	
Feeling Fearful		Sudden feeling of panic		Frequent conflicts	
Physical complaints of pain		Muscle Tension		Bedwetting or Day wetting	
Problems with anger		Acting violently		Nightmares	
Thoughts of hurting or killing others		Thoughts of hurting or killing self		Exaggerated sense of worth	
Hear or see things others do not		Over-tired or easily fatigued		Flash-backs	
Firesetting		Racing thoughts			
Sleeping less		Sleeping More			
Other:					

Alcohol and Substance Use

NOTE: Please answer to the best of your knowledge. Clinician will review in private with child.

1. Please indicate how often child / you have a drink that contains alcohol?
___ Never ___ Once a mo. or less ___ 2-4 / month ___ 2-4 / week ___ 4 or more / week
On a typical day when drinking, how many drinks containing alcohol are consumed?
___ 1 or 2 ___ 3 or 4 ___ 5 or 6 ___ 7 to 9 ___ 10 or more
What type of alcohol do you prefer to drink? _____ Typical ounces per drink: _____

2. Is marijuana or other "recreational" drugs used? ___ Y ___ N If yes, provide names, typical amount, and frequency: _____
_____
At what age did you first use? _____ Have you ever stopped? _____ For how long? _____

3. Do you currently use any tobacco products? ___ Y ___ N At what age did you start: _____
Product: _____ How much per day: _____ Have you ever quit? ___ Y ___ N

Relationship and Family Information

1. Siblings living in same home:

First & Last Name	Age	F / M	Primary	Step	How well do they get along?

2. Please provide name, relationship and age of anyone else living with you: _____
_____

3. Best friends or adult family members or friends your child may spend a lot of time with or overnight?

Name: _____ Relationship: _____ Age: _____ Sex: ____
Name: _____ Relationship: _____ Age: _____ Sex: ____
Name: _____ Relationship: _____ Age: _____ Sex: ____
Name: _____ Relationship: _____ Age: _____ Sex: ____

Family Mental Health History:

1. Please indicate below if there is a family history of any of the following conditions by checking yes or no for each one. If yes, provide family member relationship (father, mother, sister, grandmother, etc).

Condition	Yes	No	Relationship
Alcohol or Substance abuse			
Anxiety			
Depression			
Domestic Violence			
Eating Disorders			
Obesity			
Obsessive Compulsive Behavior			
Schizophrenia			
Suicide Attempts			
Bi-Polar			
Other:			

2. Please list any family members, friends, support groups, or community groups that are helpful to child.

_____

_____

3. Please indicate if child has experienced any of the following abuse:

___ Emotional ___ Sexual ___ Physical If so, at what age: _____ For how long: _____

From Whom: _____Relationship: _____Age: _____

4. Has a family member or close friend committed suicide? ___ Y ___ N Who: _____

5. Is child having thoughts of harming self? ___ Y ___ N Someone else: ___ Y ___ N

If another, who? _____ Is there access to a gun or other weapon? ___ Y ___ N

6. Is there anything else you think is important for us to know? _____

_____

_____

Misc. Information (Clinician will ask child)

1. Do you enjoy school? ___ Y ___ N Do you find it stressful? ___ Y ___ N

If yes, please rate your stress on a scale of 1 to 10: ____ Is this level OK with you? ___ Y ___ N

What do you like MOST about it? _____

_____

What do you like LEAST about it? _____

_____

2. Do you consider yourself to be religious ___ Y ___ N spiritual ___ Y ___ N

If yes to either of these, please describe how you express this aspect of self: _____

_____

3. If you could change just ONE thing in your life, what would it be? _____

_____

Referral Source

How did you learn about this office? ___ Friend ____ Internet ____ Physician or other health professional ____ Other: _____

If referred by a professional or friend, may I have your permission to mention your name and thank them for the referral? ___ Y ____ No

If Yes: Name & Number: _____ Please initial here: _____

By signing below I confirm that the above information is true and correct.

My signature below indicates my desire and consent to have my child participate in mental health counseling sessions and services with Maureen McLain, MS, RMHCI.

I understand that we have the right to agree to or to refuse these services at any time.

Mother (signature): _____ Printed: _____

Dated: _____

Father (signature): _____ Printed: _____

Dated: _____

Child (signature): _____ Printed: _____

Please use the space below for ANYTHING you believe it would be helpful for the therapist to know.