Turning Pointe Counseling & Consulting, LLC
Child/Adolescent Information Form

Please fill out the below information to assist me in helping your child. Information will be treated as private and confidential. If a certain question(s) do not apply to the child, please mark them as N/A.

Child's Name: ____ Today's Date: ___________

Address: ____

City: ________________________ State: ______________________ Zip: ___________

Date of birth:________________ Age: _______ Race:_______ Gender: ____M ____ F

Home Phone #: ______________________________ Okay to: Call _____ Leave a message ______

Cell Phone #: _______________________________ Okay to: Call _____ Leave a message ______

Your Name: ____ Relationship: ____________

Street Address: ____

City: ________________________ State: ______________________ Zip: ___________

Social Security Number: _______/_____/________ DOB: _______/______/_________

Home Phone #: _____________________________ Okay to: Call _____ Leave a message ______

Cell Phone #: _______________________________ Okay to: Call _____ Leave a message ______

Work Phone#: ______________________________ Okay to: Call _____ Leave a message ______

E-mail: ____ May I email you? ____Yes ____No
**Please note: Email correspondence is not considered to be a confidential medium of communication*

Referred by (if any): ____

Responsible Party Information: Please indicate who will be financially responsible for payment of services; please complete the following if information concerning the responsible party is different then the above.

Responsible Party Name: ____

Street Address: ____

City: ______________________ State: ______________ Zip: _______________

Social Security Number: _______/_____/________ DOB: _______/______/_________

Relationship to Client: ☐ Parent / Guardian ☐Other___________________

Home Phone:___________________ Work phone: _______________ Cell Phone: __________________

Home Phone #: ______________________________ Okay to: Call _____ Leave a message ______

Cell Phone #: _______________________________ Okay to: Call _____ Leave a message ______

Emergency Contact:

Name___________________________ Phone#______________ Relationship: _________________

Counseling Information

Is your child receiving counseling services at present? ☐ Yes ☐No

If Yes, please briefly describe: ____

____

Name of Counselor: ____

Has your child received counseling in the past? (including treatment for drug or alcohol) _______Yes __ No

If Yes, please briefly describe: ____

____

Name of Counselor: ____

Outcome of previous treatment: ____

Why is your child coming to counseling? (Use the back of this sheet if necessary) ________________________

____

____

____

____

____

____

How long has this problem persisted____

____

____

____

Under what conditions does his/her problem usually get worse? ______________________________

____

____

____

Under what conditions does his/her problem usually improve? ______________________________

____

____

____

What significant life changes or stressful events has your child experienced recently?

____

____

____

List you child's greatest strengths: ____

____

____

____

List your child's greatest weaknesses: ____

____

____

____

List any social difficulties: ____

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____

____

List any difficulties at school: ____

____

____

____

List any difficulties at home: ____

____

____

____

What would you like to see your child accomplish in counseling?

____

____

____

____

School Information

School:____ Grade: ______________

Placement: ☐ Regular ☐ Special Education ☐ Home-Schooled ☐ Other ______________

Does your child experience any of the following (please check all that apply):

☐ Poor Grades ☐ Poor Attendance ☐ Suspension/Expulsion

Does you child participate in any extra curricular activities: ☐ Yes ☐ No

If yes please list: ____

Is your child employed: ☐ Yes ☐ No

If yes: Name of Employer: _______________________ How many hour per week: ______________

Developmental History

Do you have any concerns about your child's developmental history in the following areas:

Social Development: ☐ Yes ☐No
Physical Development: ☐ Yes ☐No
Language: ☐ Yes ☐No
Intellectual Ability: ☐ Yes ☐No
Emotional Expression: ☐ Yes ☐No

If you answered yes, please explain: ____

Medical Information

Name and address of your child's primary physician:
Physician's name: ____
Address: ________________________________ Phone#________________________

List any major illnesses and/or operations your child has had:

____

____

Has your child ever been hospitalized?: ☐ Yes ☐No Explain: _________________________

____

Any *current* medical concerns? ☐ Yes ☐No Explain: _________________________

____

Any *past* medical concerns? ☐ Yes ☐No Explain: _________________________

____

Has your child ever been tested for psychological/psychiatric issues? ☐ Yes ☐No

On average how many hours of sleep does your child receive nightly? __________________________

Does your child have trouble falling asleep at night? ☐ Yes ☐No
If yes, how long has this been a problem? _______________
Does your child regularly waken at night? ☐ Yes ☐No
Does your child regularly have bad dreams? ☐ Yes ☐No

Describe your child's appetite: ☐ Poor ☐Average ☐ Large
Has your child's weight changes in the past year?: ☐ Yes ☐No / ☐ Gained ☐ Lost
If Yes, Explain and by how much: ____

____

What medications (and dosages) is your child taking at present, and for what purpose?

Medication	Purpose
______________________________	____
______________________________	____
______________________________	____
______________________________	____
______________________________	____
______________________________	____

Family History

Mother's age: ________ If deceased, how old was the child when she passed away? ________

Father's age: _________ If deceased, how old was the child when he passed away? ________

Number of brother(s): _____ Their ages: _____ _____ _____ _____ _____ _____

Number of sister(s): _____ Their ages: _____ _____ _____ _____ _____ _____

Briefly describe the child's relationship with his/her siblings: ____
____

Parent's marital status: ☐ Married ☐ Divorced ☐ Separated ☐ Never Married ☐ Widowed
(If parents are not married, the child's age when divorced, separation or parent's death occurred?) _________

Living situation: ☐ Parent's Home ☐ Relative's Home ☐ Foster Home ☐Other________________

Household Members Names: *(if client lives in more than one household mark 1 – 2)*	Relationship to child	Age	Occupation or school	Level of Education
________________________	_______________	______	_______________________	____________
________________________	_______________	______	_______________________	____________
________________________	_______________	______	_______________________	____________
________________________	_______________	______	_______________________	____________
________________________	_______________	______	_______________________	____________
________________________	_______________	______	_______________________	____________
________________________	_______________	______	_______________________	____________
________________________	_______________	______	_______________________	____________

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to your child in the space provided (father/mother, grandfather/grandmother, uncle/aunt, etc.).

	Please Circle List	Family Member
Alcohol/Substance Abuse	yes / no	
Anxiety	yes / no	
Depression	yes / no	
Domestic Violence	yes / no	
Eating Disorders	yes / no	
Obesity	yes / no	
Obsessive Compulsive Behavior	yes / no	
Schizophrenia	yes / no	
Suicide Attempts	yes / no	

Symptoms and Behaviors

Please check any behaviors and/or symptoms that have occur in the last 4 weeks:

___ academic problems
___ alcohol use
___ antisocial behavior
___ avoiding people
___ chest pain
___ decreased need for sleep
___ disorientation
___ distractibility
___ dizziness
___ drug use
___ elevated mood (persistent)
___ excessive hand washing
___ excessive checking
___ excessive or reckless spending
___ excessive exercise
___ excessive dieting
___ failure to complete tasks
___ negative body image

___ fatigue
___ fear of embarrassment
___ feelings of hopelessness
___ hallucinations
___ heart palpitations
___ high blood pressure
___ hyperactive: fidgets, squirms
___ inflated feelings of self-worth
___ impulsivity
___ irritability
___ judgment errors
___ loneliness
___ memory impairment
___ mood shifts
___ panic attacks
___ persistent sad feelings
___ racing thoughts

___ recurring thoughts
___ recurring dreams
___ self induced vomiting
___ sexual difficulties
___ short attention span
___ self harm (cutting, ect)
___ speech problems
___ startle easily
___ talking excessively
___ tire easily
___ thoughts of suicide
___ thoughts disorganized
___ trembling/feeling shaky
___ use of laxatives/diuretics (to loose weight)
___ withdrawing
___ worry a lot

_________other (specify)________________________________

Please give examples of how each of the symptoms you checked has impaired your child's ability to function

(e.g., socially, emotionally, occupationally, physically).

Use the back of this sheet if necessary.

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Substance Abuse History

Has your child ever received inpatient drug and/or alcohol drug treatment? ☐ Yes ☐No

If yes When? ______________________ Where? _______________________________

Has your child ever received inpatient drug and/or alcohol drug treatment? ☐ Yes ☐No

If yes When? ______________________ Where? _______________________________

Is your child currently using drugs and/or alcohol? I ☐ Yes ☐No

If Yes please describe current use:

Drug/Alcohol type	Age of first use	Date of last Use	Frequency	Amount