Counseling Center at Heritage
HELPING YOU FIND YOUR WAY

New Client Information: Child and Adolescent

(To be completed by Parent or Guardian)

Child's Name _____Date of Birth _____
First *Middle* *Last*

Gender [] Male [] Female School _____ Teacher _____ Grade ____

Address: _____

Name of parent or guardian with whom child lives _____ Home Phone Number _____

Pediatrician _____ Pediatrician Phone Number _____

Describe the behaviors or emotions exhibited by the child that concern you:

_____
_____
_____
_____
_____

When did you first notice these problems?

_____

Why do you think your child shows these emotions or behaviors?

_____
_____

What would you rather see your child doing instead?

_____
_____
_____
_____

When do you see your child happy and behaving in a positive way?

_____
_____
_____
_____

FAMILY DATA

Mother's Name _____Occupation _____

Employer _____Work Phone Number (Optional) _____

Mother's Work Schedule _____

Father's Name _____ Occupation _____

Employer _____Work Phone Number (Optional) _____

Father's Work Schedule _____

Step-parent's Name _____Occupation _____

Employer _____Work Phone Number (Optional) _____

Marital Status of Parents _____
If parents are separated or divorced, how old was child when the separation occurred? _____

Recent Traumatic Events _____
_____

Ages of Brothers and Sisters living in the home: Brothers _____ Sisters _____

List other individuals living in the home _____

Describe the room in which your child resides: _____Single Room ____ Shares Room with _____

Does custodial parent work outside the home? _____
If yes, who is the primary caregiver when the parent(s) is away? _____

What are the child's responsibilities at home? _____

Does your child have difficulty making friends? _____

How does he/she get along with the children in the neighborhood? _____

Describe his/her relationship with other children in the family: _____

Does your family participate in religious services? _____ If yes, what type? _____

In what activities does the family participate as a family unit? _____

Are there any family problems that may be contributing to the child's present difficulties? _____
_____

_____

Does anyone in the family have any of these concerns (i.e., Mom, Dad, Grandparents, Aunts, Uncles, Cousins)

Anxiety _____ Depression _____ ADD/ADHD _____

Bipolar Disorder _____ Schizophrenia _____ Obsessions/Compulsions (OCD) _____

Suicide _____ Learning Problems _____ Mental Retardation _____

Eating Disorder _____ Anger Problems _____ Autism/Asperger's Disorder _____

Substance Abuse/Alcohol Abuse _____ Other _____

SCHOOL HISTORY

What grade(s) has your child repeated? _____ Please List Other Schools Attended _____

What are your child's best subjects? _____

Worst subjects? _____

If your child is experiencing a problem, what do you perceive the problem to be? _____
_____

When was it first noticed? _____What is his/her attitude toward school? _____

Describe your child's study habits at home _____
_____

Who is the primary person who helps with homework? _____

How much time is spent on homework each night? _____

Has your child passed state assessment tests like the PSSA? _____

BIRTH HISTORY

List any illnesses or accidents occurring during pregnancy_____
_____

Full Term: [] Yes [] No Birth Weight _____

Delivery: [] Normal [] Breech [] Cesarean

Did any of the following occur during pregnancy:
_____ Tobacco Use _____ Alcohol Use _____ Other Drugs or Substances

_____ Gestational Diabetes _____ Prescribed Medications _____ Anemia or Toxemia
_____ Elevated Blood Pressure _____ Injury or Accident _____ Emotional Trauma
_____ Domestic Violence

Was there any evidence of injury at birth? [] Yes [] No
If yes, please explain: _____

Were any of the following experienced before the child's second birthday?
_____ Feeding problems _____ Seizures/Convulsions _____ High fever
_____ Fainting _____ Serious accidents _____ Head injuries

Please give additional information on any item checked above: _____
_____

DEVELOPMENTAL DATA

Does your child have a history of ear infections? [] Yes [] No

At what age did each of the following behaviors first occur?
_____ Crawling _____ Sitting Up _____ Fed Self _____ Walking Alone
_____ Dressed Self _____ Toilet Trained During Day
_____ Speaking first words besides "Ma-Ma" and "Da-Da"
_____ Tied Shoes
_____ Speech was clearly understood by others outside the family

Characteristics of child temperament in infancy/early childhood:
_____ Good Natured _____ Sluggish _____ Irritable _____ Active
_____ Resistant to touch _____ Cuddly _____ Easily Soothed _____ Affectionate
_____ Anxious _____ Clinging _____ Difficulty Separating _____ Shy or Timid

Has your child ever experienced or witnessed any physical abuse, domestic violence, sexual abuse, emotional abuse, or neglect?
_____
_____

Are you aware of or suspect that your child has ever used tobacco, alcohol, or drugs? [] No [] Yes (explain)
_____
_____
_____
_____

PHYSICAL CONDITION

Do you notice, or has a doctor reported, any of the following in this child:
Serious medical problems: _____

Serious Injury: _____

Childhood Diseases: _____

Seizures: _____

Hospitalization: _____

Allergies: _____

Date of last physical examination: _____

Please list Medications Prescribed and Dosages: _____

Date of last hearing and vision screening: _____

Agencies or specialists that have worked with your child:

_____ Mental Health Clinic _____Family Physician _____ Social Worker
_____ Psychologist _____Psychiatrist _____ Department of Human Service
_____ Department of Juvenile Justice (probation officer) (DHS)

If checked, please give the following information:

NAME	TITLE	DATES

Has your child had any mental health hospitalizations?

HOSPITAL	DATES	REASON

My child's general condition is:

[] Seems to be in good health [] Tires easily, listless, lacks energy [] Overweight
[] Sleeps too much [] Underweight [] Sleeps too little
[] Overly active, always on the move [] Awkward in running, walking, or playing

BEHAVIORAL CHECKLIST

(Please check the behaviors that best describe your child)

[] Feels happy with him/herself [] Sucks his/her thumb [] Demands excessive attention
[] Overly dependent on others [] Wets the bed [] Plays well with other students
[] Overly anxious to please [] Cries often [] Exhibits uncooperative attitude
[] Tries to control others [] Poor self-control [] Has very few close friends
[] Relates well to adults [] Friendly [] Lacks motivation, lazy
[] Aggressive [] Sad or depressed often [] Does not adjust readily to change
[] Fearful [] Shy, withdrawn [] Acts younger than other children of age
[] Openly affectionate to family [] Daydreams often [] Restless

[] Easily frustrated [] Can be trusted [] Loud
[] Jealous of brother(s)/sister(s)

DISCIPLINE USED AT HOME

1. Child is disciplined (check one) [] frequently [] occasionally [] rarely

2. Punishment is administered by [] mother [] father [] others (check all that apply)

3. What type of discipline is used? (Check all that apply) [] spankings [] loss of privileges
[] restrictions [] isolation [] talking [] rewards

4. Reactions to discipline: [] becomes angry [] cries []withdraws [] sulks and pouts [] fights back

5. Effectiveness of discipline: [] behavior improves [] remains same [] behavior changes [] behavior worsens

6. Bedtime hour _____ Time of getting up in the morning _____

7. What concerns you most about your child? _____
_____
_____

8. List your child's major interests (sports, hobbies, activities) _____
_____
_____

9. What do you enjoy most about your child? _____
_____

10. Add any additional information here
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Signature of Person Providing Information Date