Texas Premier Counseling Services

www.TexasPCS.org
(972) 895-2502
Support@TexasPCS.org

CHILD / ADOLESCENT INFORMATION FORM

Full Name: _____
First *Middle* *Last*

Date of Birth: _____ Age: _____ Gender: ○ MALE ○ FEMALE

Medical History

Name of Primary Care Physician:_____

Physician Address: _____ Physician Phone: _____

Date of Last Medical Evaluation: _____ Date of Next Appointment: _____

Is your child under the care of a psychiatrist or been treated by a psychiatrist in the past? ○ YES ○ NO

If YES, Psychiatrist Name_____

Psychiatrist Address: _____ Psychiatrist Phone: _____

Date of last Psychiatric Appointment: _____ Date of Next Appointment: _____

Often times it is best to coordinate treatment with a Primary Care Physician or a Treating Psychiatrist for a continuity of care. Do you consent to coordinate care with the above Physicians?

Primary Care Physician _____ ○ YES ○ NO ○ N/A

Treating Psychiatrist _____ ○ YES ○ NO ○ N/A

Please sign here for either answer: _____

Current medications being taken:

1 . _____ Dosage/Freq:_____ Start Date: _____Purpose: _____

2 . _____ Dosage/Freq:_____ Start Date: _____Purpose: _____

Prescribed by:_____

Is your child under the care of a counselor or been treated by a counselor in the past? ○ YES ○ NO
If YES, please provide the name, phone number, fax, and e-mail of any previous therapist and attach it to this form.

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Has your child ever been hospitalized for medical or psychiatric reasons? ○ YES ○ NO

Hospital	Month / Year	Reason

Are you aware of your child using any recreational drugs? ○ YES ○ NO

If YES, is your child currently using, that you are aware of? ○ YES ○ NO

Type of Drug	Quantity	How Often

Are you aware of your child experimenting with alcohol? ○ YES ○ NO

If YES, please list:

Type of Alcohol	Quantity	How Often

Does your child smoke cigarettes or any other forms of tobacco? ○ YES ○ NO

If YES, what kind? _____

Describe any important medical history, chronic ailments, or other health problems your child has experienced:

_____

_____

_____

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Describe any other health problems or important medical history about your child's immediate family members:

_____

_____

_____

Does your child have any close relatives (*father, mother, brother, sister, grandparent*) who have experienced depression, anxiety, or other emotional difficulties? ○ YES ○ NO If YES, please list:

_____

_____

_____

School and Family History

Has your child experience any developmental, academic, or behavioral problems as a child or while in school with peers or teachers? ○ YES ○ NO If YES, please explain below:

_____

_____

_____

Is your child Homeschooled? ○ YES ○ NO

1. School(s) currently attending: _____ Dates: _____

2. Last school attended: _____ Dates: _____

Describe your child's current support network: (*friends, relatives, community*):

_____

_____

_____

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Biological Parents – Please check all of the information that applies to the biological parents of child:

Mother	☐ Living	**Father**	☐ Living
	☐ Deceased		☐ Deceased
	☐ Divorced		☐ Divorced
	☐ Remarried _____# of times		☐ Remarried _____# of times

With whom does your child live (*if two homes list both parents*)? _____

What, if any, legal orders are in place? _____

****** Copy orders to be placed in client's file must be on file prior to services. ******

Does your child consider someone other than your biological parents (step-parent, grandparents, etc.) to be one or both of your "real" parents? ○ YES ○ NO If YES, whom? _____

Do both biological parents live in the home? ○ YES ○ NO

If NO, where do biological parents live?

Mother: _____

Father: _____

If possible please have both biological parents fill the next questions out:

Mom, please describe your relationship with your child:

_____

_____

_____

Dad, please describe your relationship with your child:

_____

_____

_____

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List the first names and ages of siblings:

Name	Age	Relationship (*natural, step, half, etc.*)

Has the child experienced or been witnessed to any of the following experiences in the home, currently or in the past? (*Check all that apply.*)

☐ Alcohol Abuse ☐ Drug Abuse ☐ Sexual Abuse ☐ Physical Abuse ☐ Emotional Abuse

Please explain, if any above is checked:

_____

_____

_____

_____

_____

_____

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About Your Child

Please check any of the following that describe how you believe your child has been feeling/acting lately:

☐ Sad	☐ Angry	☐ Tearful
☐ Anxious	☐ Ashamed	☐ Irritable
☐ Depressed	☐ Aggressive	☐ Confused
☐ Frightful	☐ Resentful	☐ Extreme Ups / Downs
☐ Guilty	☐ Worthless	☐ Jealous
☐ Hopeless	☐ Helpless	

Describe any behaviors your child has demonstrated that cause concern:

_____

_____

_____

Any changes in your child's sleeping habits? ○ YES ○ NO Please describe:

_____

_____

_____

Any changes in your child's eating habits? ○ YES ○ NO Please describe:

_____

_____

_____

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Has your child told you of any suicidal thoughts or feelings? ○ YES ○ NO If YES, please give a brief description with dates:

_____

_____

_____

Has your child attempted suicide recently or in the past? ○ YES ○ NO If YES, please give a brief description with dates:

_____

_____

_____

Has your child tried to hurt others or animals recently or in the past? ○ YES ○ NO If YES, please explain:

_____

_____

_____

Please describe what activities your child participates in:

_____

_____

_____

Please describe your child's level of physical activity:

_____

_____

_____

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How much time does your child play on the computer, watch TV, or play video games:

_____

_____

_____

Is there any other information regarding your child that you would like to share with the child specialist that is not covered on this form? You may also use this space to complete earlier responses.

_____

_____

_____

_____

Please list your goals of therapy for your child:

_____

_____

_____

_____

_____

_____

_____

Printed Name | Signature

Relationship to Minor | Date

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