## Client Information Form-Child/Adolescent



Date: _____

**Child/ Adolescent Information**

Name: _____

Date of birth: _____ Age: _____ Gender:_____ Race/Ethnicity: _____

Address: _____

Home phone number: _____ Cell: _____

**Adolescent Employment**

Employer: _____

Address: _____ Telephone: _____

Job Title: _____ Full or part time _____

**Caregiver Information**

Name: _____

Address: _____

Home phone number: _____ Cell: _____ Work: _____

Who is legally authorized to receive information or make decisions regarding this child's care?

Name: _____ Relationship:_____

In case of an emergency contact: Name: _____

Address: _____

Phone: _____ Relationship: _____

Briefly describe why you are here:

_____

_____

What changes would you like to see?

_____

_____

Child's hobbies or recreational interests:_____ _____

_____

Please list at least three things your child likes about him or herself:

_____

_____

Michelle D. Scheu, LSCSW 1999 N. Amidon Suite 208 Wichita, KS 67203 Phone: 316-440-4288 Fax: 316-440-4449 michelle@mscheu.com

**Child's Social History:**

Please list parent and sibling information.

| Name | Age | Living in the child's home? | Relationship (good, fair, poor) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Are parents currently married? _____ yes _____no _____ n/a If parents are divorced are there custody issues? _____ yes _____no

If yes, please explain: _____

_____

What are the current visitation arrangements? _____

_____

Has your child experienced the death of significant family members? ___ yes ___no If yes, whom? _____ year of death _____

**Religious History:**

Does your child practice a religious or spiritual belief now? ____ yes ____no

If yes, please define: _____

**Educational History:**

Name of child's school: _____Current grade: _____

Please explain any behavioral or academic issues:

_____

_____

Describe your child's interaction with peers: _____

Does your child have a history of contact with law enforcement? ___ yes ___ no If yes, please explain:

_____

_____

Does your child have any current pending charges? ____ yes ____ no

If currently on probation: Name of probation officer: _____ Telephone: _____

**Child's Medical History:**

Primary Care Physician: _____

Address: _____ Telephone: _____

Has your child had a physical within the last 12 months? _____ yes _____ no

Physical health is: _____ good _____ fair _____ poor

Please circle any of the following chronic disease or disorders your child has been diagnosed with:

Head injury Hypoglycemia High Blood Pressure Migraine/Headaches Diabetes Ulcers

Heart problems Thyroid problems Liver/Kidney problems Seizures Sleep Disorder Eating Disorder

Other (please explain): _____

Is your child allergic to any medication or food? _____ yes _____no If yes, please describe: _____

_____

Current medications (prescribed and over the counter): _____

Were there any concerns with pregnancy or child birth? ___yes ___no If yes, please describe:

_____

Did your child meet developmental milestones on time? ___yes ___ no If no, please describe:

_____

Our family medical history includes (circle all that apply):

| | | | | |
|---|---|---|---|---|
| Diabetes | Substance Abuse | Suicide | Bi-polar Disorder | Schizophrenia. |
| Depression | Heart Problems | Anxiety | Psychiatric Hospitalizations | Other medical issues: _____ |

Is your child experiencing any changes in appetite or sleep patterns? ___yes ___no If yes, please circle all that apply:

Decreased appetite Increased appetite Binge Eating Hoarding Food Picky Eater Throwing up on purpose

Decreased sleep Increased sleep Trouble waking up in the morning Nightmares Night waking

Please circle any of the following that your child is experiencing:

| | | | |
|---|---|---|---|
| Sadness | Feelings of guilt | Anxiety | Irritability/anger |
| Reduced energy | Difficulty thinking | Suicidal thoughts | Suicide attempts |
| Intentional self-injury | Feeling hopeless | Extreme changes in mood | Sexual behaviors |
| Worries | Fears | Poor memory | Stress |
| Difficulty concentrating | Restlessness | Easily distracted | Isolation |
| Conflict with others | Physical aggression | Problems at school | Verbal threats |
| Reduced interest in activities | Hearing things others don't hear | Seeing things that others do not see | |

Other (please explain): _____

How long has your child been experiencing these behaviors? _____

How often do they occur? _____

Does your child have a history of substance use? ____ yes _____ no

**Prior Mental Health Treatment History:**

Please complete the following if your child has a history of therapeutic services:

| Where | When | Diagnosis | Current Status |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Has your child been hospitalized for psychiatric issues? ____ yes ____ no

If yes, name of psychiatric facility: _____ Date of discharge: _____

Has your child ever been physically, emotionally or sexually abused? _____ yes _____ no

Has your child had suicidal thoughts? _____ yes _____ no

Has your child ever intentionally hurt him or herself? _____ yes _____ no

Has your child ever intentionally hurt someone else? _____ yes _____ no

Does your child appear to feel hopeful about the future? _____ yes _____ no

By signing below, I acknowledge that the Client Rights/Responsibilities and Notice of Privacy Practices notice for Michelle D. Scheu, LSCSW, LLC is posted on mscheu.com and in the office. I may receive/waive receipt of a copy of this document at the time of first appointment.

_____

Client or Responsible Party Signature Date Relationship