Dynamic Counseling Services
Adolescent Client Information

Child's Name: _____ D.O.B.: _____ Age:_____

School:_____ Phone:_____ Teacher:_____ Grade: _____

How does your child do in school academically? _____

How does your child do in school behaviorally?_____

Does your child have a learning or physical disability? __Y, __N, __Maybe. Specify: _____

_____

Does your child have a mental health diagnosis? __Y, __N, Specify: _____

_____

Does your family have any specific spiritual beliefs? _____

Medical History

During pregnancy, did mother use: __ Cigarettes, __ Alcohol, __ Drugs, __ Experience Extreme Stress?

Specify frequency, amounts, and duration: _____

List any birth complications (Ex: Premature, jaundice, C-section, etc.)_____

_____

List any Medical conditions or history (Ex: Surgeries, broken bones, allergies, etc.)_____

_____

Does child use: __ Cigarettes, __ Alcohol, __ Drugs

Specify amount and frequency: _____

Primary Care Physician: _____ Phone:_____Last seen on: _____

Current medications: (Include dosage and frequency):_____

_____

Medication Allergies: _____

Other Allergies: _____

In the first two years, did your child experience:

__Separation from mother, __Out of home care, __Disruption in bonding, __Depression of mother,

__Abuse, __Neglect, __Chronic pain, __Chronic Illness, __Parental Stress

If yes, please specify: _____

_____

Reached developmental milestones: __On time, __Early, __Late

How many times has the child moved homes? _____

What are five adjectives that describe:

Mother: _____

Father: _____

Child: _____

Parental Relationship: _____

Family History

Biological Dad:_____ DOB:_____ Biological Mom:_____ DOB:_____

__/__/__ Married; __/__/__ Separated; __/__/__ Divorced

Siblings (1st to last):

Name: _____Age:____Name: _____ Age:____

Name: _____ Age: ____Name: _____ Age:____

Name: _____ Age: ____Name:_____Age:____

Custodial Adults (If not biological parents): Dad: _____ DOB:_____

Mom: _____ DOB: _____ Date became caretaker: _____

People in household, if different from above: _____

_____

Does father work outside of the home? __Y, __N; Occupation: _____ Hours:_____

Father's highest level f education: _____

Does mother work outside of the home? __Y, __N; Occupation: _____ Hours:_____

Mother's highest level f education: _____

If separated or divorced, visitation schedule: _____

Does either parent have legal issues? _____

List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.): _____

_____

Have children witnessed domestic violence? __Y, __N, Specify: _____

_____

How is your child disciplined? Please list each method and frequency of use: _____

_____

_____

Trauma History

Has your child been verbally abused? __Y, __N, __Suspected. Specify: _____

_____

Has your child been physically abused? __Y, __N, __Suspected. Specify: _____

_____

Has your child been sexually abused? __Y, __N, __Suspected. Specify: _____

_____

Other stressors or traumas? _____

_____

Circle the symptoms your child displays and the number of times per week symptom is displayed:

Anger	Anxiety	Bed wetting	Acts out sexually
Conduct problems	Controlling	Day defecation	Has unusual sexual knowledge
Day wetting	Defiance	Depression	Homicidal thoughts or actions
Disassociates	Drug or alcohol use	Hyperactivity	Masturbates excessively
Hyper vigilance	Impaired conscience	Isolation	Lack of empathy
Lack of motivation	Lethargy	Low impulse control	Plays out violent themes
Low self-esteem	Lying Nightmares	Plays out sexual themes	
Obsesses	Over/Under eating	Phobias	Peer problems
Phobias	Running Away	Shy	Sleeplessness
Stealing	Tantrums	Somatic Symptoms: Headaches/Stomachaches, etc.	

Other symptoms: _____

How does your child handle anger? _____

_____

Has the child experienced any significant loss? If yes, explain: _____

_____

What do you view as your child's major strengths and positive traits?_____

_____

What are your child's hobbies? _____

_____

Briefly describe your goals for your child's therapy: _____

_____

Please list any information you deem to be important for the therapist to know: _____

_____