QUADRA Counseling Associates, LLC

CHILD/ADOLESCENT PATIENT INFORMATION

Client Name: _____ **DOB:** _____ **Date:** _____

Client Address: _____ **Gender M:** ____ **F** ___

Client City/State/Zip: _____ **Phone:** _____

Ok to leave message? _____

Who referred you to Quadra? _____

Guardianship Status: ___Self ___Parent(s) ___Other (Please Specify: _____)

Parent(s)/ Guardian(s):

1. **Name:** _____ **Relationship to client:** _____

   Address: _____ **Phone:** _____

   City/State/Zip: _____ **Ok to leave message?** _____

   Is this person an emergency contact? Yes___ No ___

2. **Name:** _____ **Relationship to client:** _____

   Address: _____ **Phone:** _____

   City/State/Zip: _____ **Ok to leave message?** _____

   Is this person an emergency contact? Yes___ No ___

Client Name: _____ **DOB:** _____ **Date:** _____

Primary Care Physician:

Name: _____ **Phone:** _____

Psychiatrist/ Nurse Practitioner:

Name/ Credentials: _____ **Phone:** _____

Allergies/ Relevant Emergency Medical Information:

_____

_____

Symptoms: (check all that apply)

- ❑ Depressed Mood
- ❑ Grief
- ❑ Anxiety/fear/worry
- ❑ Uncooperative/Irritable
- ❑ Frequent interrupting
- ❑ Disorganized
- ❑ Lack of respect for authority
- ❑ Runaway behavior
- ❑ Swearing/Potty talk
- ❑ Underactive
- ❑ Tics (involuntary rapid movements, noises or words)
- ❑ Obsessive/ritualistic behavior
- ❑ Impulsiveness/hyperactivity
- ❑ Fire-setting/playing with fire
- ❑ Shyness/Isolation
- ❑ Lying
- ❑ Stealing
- ❑ Lack of affection
- ❑ Bullies or provokes others
- ❑ Victim of bullying
- ❑ Cruelty toward animals
- ❑ Difficulty adjusting to parental divorce/remarriage/new sibling
- ❑ Difficulty adjusting to a new move/new school/new friends
- ❑ Inappropriate sexual behavior
- ❑ Rocking or repetitive behavior
- ❑ Sleep difficulty/nightmares
- ❑ Truancy/school refusal
- ❑ Appetite Problem
- ❑ Excessive crying
- ❑ Frequent chewing odd objects/clothes
- ❑ Head banging
- ❑ Bed wetting/soiling after age 3
- ❑ Temper tantrums
- ❑ Hyperactivity
- ❑ Oppositional/Defiant Behavior
- ❑ Difficulty with Sleep
- ❑ Difficulty Concentrating
- ❑ Emotional Trauma
- ❑ Physical Trauma
- ❑ Sexual Trauma
- ❑ Substance Abuse
- ❑ Other (specify)

_____

Symptoms have been present for:

❑ Less than 1 month ❑ 1-6 months ❑ 6-12 months ❑ 12 months or more

Who are your child's legal guardians? If applicable (i.e. parental divorce), please indicate terms of legal and physical custody:

Name: _____ **Relationship to Client:** _____

__ Legal Custody __ Physical Custody

Name: _____ **Relationship to Client:** _____

__ Legal Custody __ Physical Custody

**** Please submit a copy of guardianship paperwork to your clinician, to be filed in your child's record***

Client Name: _____ **DOB:** _____ **Date:** _____

What are the presenting concerns that bring you here today?

Can you describe your home/ living situation? Do you have any concerns about the stability of your living situation?

Who lives in your home currently? Any pets?

Are there any other family members in or out of the home that are significant in your child's life?

Does your family/extended family have any history of mental health or substance abuse concerns?

Is your child actively involved in your community (i.e. sports teams, youth group, YMCA membership)?

How does your child do with making friends? Social connections? Understanding social situations?

Do you have any faith/religious type beliefs? If so, please indicate the faith (Islam, Christianity, Judaism, Atheism, etc.) and what role it plays in your life:

Does your child have any medical issues? How is your child's overall physical health?

Client Name: _____ **DOB:** _____ **Date:** _____

Has your child met all developmental milestones on time? Are you aware of any developmental delays? If so, what interventions have you used/ are you currently using?

Is your child able to self-care (i.e. brush teeth, clean room, get dressed, adhere to a schedule, complete chores and homework) in an age-appropriate manner? Do you have to give verbal prompts? Do you have to physically assist?

The following four questions are related to your child's education/academic achievement:

What school does your child attend? Grade?

How is your child's school achievement? Attendance?

Any concerns with school behaviors? Does your child see a guidance counselor at school?

Is your child on a 504 plan or Individual Education Plan (IEP)?

(If your child is 16+ only): Does your child have a plan for continuing education after completing high school? Ideas for a career path? Do you have concerns about your child's vocational/ educational future?

Do you have any concerns about your child using drugs or alcohol? Smoking cigarettes?

Does your child currently have a diagnosed mental health condition? Learning Disability? Can you please describe any previous therapy or other formal mental health services received?

Client Name: _____ **DOB:** _____ **Date:** _____

Has your child ever been hospitalized for mental health reasons? Does your child receive services through the Department of Mental Health?

Please list all current psychotropic medications your child is prescribed, including dosages.

Do you have any concerns about the effectiveness of these medications?

Who is your child's current prescriber?

Please list any past psychotropic medications your child has been prescribed, approximate dates and concerns regarding side-effects or your child's response:

Does your child currently have any legal issues? Probation? CHINS (Child in Need of Services) or DYS (Department of Youth Services) involvement? Please describe:

Does your family have any current or past involvement with DCF (Department of Children and Families)? Please describe:

Has your child ever been the victim of emotional/ physical/ sexual abuse? What actions have been taken to protect your child?

Client Name: _____ **DOB:** _____ **Date:** _____

Do you have any concerns about your child immediate safety? Has your child made any suicidal or homicidal statements recently? In the past 24 hours? On a scale of 1-10, 1 being no way the child would try and 10 being it is very likely the child would try, how would you rate the likelihood of your child acting on these thoughts?

Do you have any concerns about your child discussing or exhibiting any self-injurious behaviors?

Do you have any concerns about anyone in your immediate family (including yourself) or anyone close to your child becoming violent? If so, please describe:

Please discuss your child's strengths, talents and interests. What are some of the most positive traits in your child that we can build off of in the therapeutic process?

What are the goals you would like to see your child accomplish through the therapeutic process?

Goal #1

Goal #2

Goal #3

Is there anything else relevant to counseling your child that you would like your child's therapist to know?

Signature of Person Completing This Form **Relationship to Client**