Family Guidance Center of Milford
CHILD/ADOLESCENT INFORMATION SHEET

Child's Name: _____**Date of Birth:** _____ **Age:** _____
Gender: _____ **Preferred Pronouns:** _____

CLIENT & FAMILY HISTORY:

Reason(s) for bringing your child to treatment: _____
_____
_____

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

Parents are: ☐ Married/living together ☐ Never married ☐ Separated ☐ Divorced ☐ Widowed
Child currently lives with: ☐ Bio parent(s) ☐ Adoptive parent(s) ☐ Foster home ☐ Homeless
☐ Grandparents ☐ Other: _____

If parents do not live together:
Custody arrangement: ☐ Joint ☐ Mom ☐ Dad ☐ Other: _____
Physical Placement: ☐ Joint ☐ Mom ☐ Dad ☐ Other: _____
Visitation Schedule: _____
What is the custody arrangement regarding physical/mental health care?: _____
_____

Household Members:
Name: _____Age: ____ Relationship: _____ Occupation/School: _____
Name: _____Age: ____ Relationship: _____ Occupation/School: _____
Name: _____Age: ____ Relationship: _____ Occupation/School: _____
Name: _____Age: ____ Relationship: _____ Occupation/School: _____
Name: _____Age: ____ Relationship: _____ Occupation/School: _____
Name: _____Age: ____ Relationship: _____ Occupation/School: _____

Does either parent have legal issues? ☐ Yes: _____ ☐ No
Is treatment court ordered? ☐ Yes: _____ ☐ No
List any family history of mental illness or substance abuse *(ex: depression, alcoholism, etc)***:** _____
_____
_____

Does your family have specific spiritual/religious beliefs? ☐ Yes: _____ ☐ No
How is your child disciplined? List method and frequency of use: _____
_____
How does your child handle anger? _____
What do you view as your child's strengths/weaknesses? _____
_____
What are your child's hobbies/interests? _____
_____
What are your child's responsibilities at home? _____
_____
How well does your child handle these responsibilities? _____
_____
Child's current support system: ☐ Friends ☐ Family ☐ Social groups ☐ School ☐ Other

EDUCATION:

School Name: _____ **Location:** _____ **Grade:** _____
How does your child do in school academically? ☐ Above Average ☐ Average ☐ Poor
How does your child do in school behaviorally? ☐ Above Average ☐ Average ☐ Poor

Any issues of: ☐ Truancy ☐ Disruptive in class ☐ Attention/focus ☐ Suspension/expulsion
Does your child have a learning or physical disability? ☐ Yes ☐ No ☐ Specify: _____

MEDICAL HISTORY:

During pregnancy, did the mother use: ☐ Cigarettes ☐ Alcohol ☐ Drugs *(specify)*: _____
List any birth complications *(premature, jaundice, C-section, etc.)***:** _____
_____
In the first two years did your child experience: ☐ Separation from mother ☐ Out-of-home care
☐ Disruption in bonding ☐ Abuse ☐ Neglect ☐ Depression of mother
☐ Chronic illness ☐ Chronic pain ☐ Parental stress *(describe)*: _____
Child reached developmental milestones: ☐ On time ☐ Early ☐ Late
Onset of puberty *(if applicable):* ☐ Normal ☐ Delayed ☐ Advanced
Date of last PCP visit: _____ **PCP Name:** _____
List child's current medications *(including over-the counter, vitamins, supplements)***:** ☐ Check here if none
Medication: _____ Strength/Dosage: _____
Medication: _____ Strength/Dosage: _____
Medication: _____ Strength/Dosage: _____
Medication: _____ Strength/Dosage: _____
Medication: _____ Strength/Dosage: _____
Is your child compliant in taking medications as prescribed? ☐ Yes ☐ No Comment: _____
Food or drug allergies: ☐ Check here if none
Allergen: _____ Reaction: _____
Allergen: _____ Reaction: _____
Allergen: _____ Reaction: _____
Allergen: _____ Reaction: _____
Allergen: _____ Reaction: _____
List any current or past medical conditions: _____
_____
Has your child received previous mental health treatment? ☐ Yes ☐ No
If yes, please list provider, reason for treatment, and dates: _____
_____
Has your child received previous treatment for alcohol or drug abuse? ☐ Yes ☐ No
If yes, please list provider, reason for treatment, and dates: _____
_____
Does your child use: ☐ Cigarettes ☐ Alcohol ☐ Drugs *(specify)*: _____

TRAUMA HISTORY:

Has your child been verbally abused? ☐ Yes ☐ No ☐ Suspected Specify: _____
Has your child been physically abused? ☐ Yes ☐ No ☐ Suspected Specify: _____
Has your child been sexually abused? ☐ Yes ☐ No ☐ Suspected Specify: _____
Has your child witnessed domestic violence? ☐ Yes ☐ No ☐ Suspected Specify: _____
Recent major changes/losses: ☐ Divorce/separation ☐ Change of Schools ☐ Move/relocation
☐ Birth of child/sibling ☐ Death of loved one ☐ Other: _____
How many times has the child moved homes? _____
Indicate the symptoms your child displays and list the number of times per week displayed:

☐ Anger	_____	☐ Conduct problems	_____
☐ Anxiety	_____	☐ Controlling defecation	_____
☐ Acts out sexually	_____	☐ Day wetting	_____
☐ Bed wetting	_____	☐ Depression	_____

- ☐ Defiance _____
- ☐ Dissociates _____
- ☐ Drug or alcohol use _____
- ☐ Headaches/stomachaches_____
- ☐ Homicidal thoughts/actions_____
- ☐ Hyperactivity _____
- ☐ Hyper vigilance _____
- ☐ Impaired conscience _____
- ☐ Isolation _____
- ☐ Lack of empathy _____
- ☐ Lack of motivation _____
- ☐ Lethargy _____
- ☐ Low impulse control _____
- ☐ Low self-esteem _____
- ☐ Lying _____
- ☐ Masturbates excessively _____
- ☐ Nightmares _____
- ☐ Obsesses _____
- ☐ Peer problems _____
- ☐ Phobias _____
- ☐ Plays out sexual themes _____
- ☐ Plays out violent themes _____
- ☐ Running away _____
- ☐ Shy _____
- ☐ Sleeplessness _____
- ☐ Stealing _____
- ☐ Tantrums _____
- ☐ Unusual sexual knowledge _____
- ☐ Other: _____

Please add any further information you feel the therapist should know: _____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____ _____

Parent/Guardian Name PRINTED SIGNATURE DATE