

# Quest Family Therapy

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## Child/Adolescent Information Sheet

*Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.*

*Please fill out this form and bring it to your first session.*

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent/ Guardian Name(s): \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ May I leave a message? Yes No

Cell/Other Phone: (\_\_\_\_) \_\_\_\_\_ May I leave a message? Yes No

E-mail: \_\_\_\_\_ May I email you? Yes No

\*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): \_\_\_\_\_

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 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: \_\_\_\_\_

Psychiatrist: \_\_\_\_\_ 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 (1<sup>st</sup> 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 of education: \_\_\_\_\_

Does mother work outside of the home? \_\_Y, \_\_N; Occupation: \_\_\_\_\_ Hours: \_\_\_\_\_

Mother's highest level of education: \_\_\_\_\_

If separated or divorced, visitation schedule: \_\_\_\_\_

What is custody arrangement regarding physical and mental health care: \_\_\_\_\_

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: \_\_\_\_\_

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

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**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/adolescent displays and list the number of times per week it is displayed:

- |                              |  |                         |
|------------------------------|--|-------------------------|
| Anger                        | Anxiety  | Bed wetting             |
| Acts out sexually            | Conduct problems                               | Controlling Defecation  |
| Has unusual sexual knowledge | Day wetting                                    | Defiance                |
| Depression                   | Homicidal thoughts 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: \_\_\_\_\_

How does your child/adolescent handle anger? \_\_\_\_\_

Has the child/adolescent experienced any significant loss? If yes, explain: \_\_\_\_\_

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What do you view as your child/adolescent's major strengths and positive traits? \_\_\_\_\_

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What are your child/adolescent's hobbies? \_\_\_\_\_

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What are your child/adolescent's responsibilities at home? \_\_\_\_\_

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How well does your child/adolescent's handle these responsibilities? \_\_\_\_\_

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Briefly describe your goals for your child/adolescent's therapy: \_\_\_\_\_

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

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Who shall I contact in case of emergency? Name: \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_

In this box, please indicate the address and telephone number you want me to use to when sending bills or when I need to contact you. If this box is left blank, I will use the address and any of the telephone numbers you have provided above.

If you do *not* want me to leave a message on your answering machine, please tell me how you want me to reach you by phone:

I hereby consent for Shawn V. Giammattei, Ph.D. to provide my child/adolescent with evaluation and treatment.

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Signature

Date