Quest Family Therapy
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Child/Adolescent Information Sheet

Please provide the following information and answer the questions below. 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? ☐Yes ☐No ☐Maybe

Specify:_____

Does your child have a mental health diagnosis? ☐Yes ☐No ☐Maybe

Specify:_____

Does your family have specific spiritual beliefs? ☐Yes ☐No

If yes, describe: _____

Medical History

During pregnancy, did your 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 the 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 ☐ Chronic pain

☐ Depression of mother ☐ Abuse ☐ Neglect ☐ Chronic Illness ☐ Parental Stress

If any checked, please explain:

_____

_____

Reached developmental milestones: ☐ On time ☐ Early ☐ Late

How many times has the child moved homes? _____

List **five adjectives** that describe the following individuals:

Primary Caregiver:

1)_____
2)_____
3)_____
4)_____
5)_____

Child:

1)_____
2)_____
3)_____
4)_____
5)_____

Co-parent:

1)_____
2)_____
3)_____
4)_____
5)_____

Parental Relationship:

1)_____
2)_____
3)_____
4)_____
5)_____

Family History

Parent 1:_____ DOB:_____/_____/_____

Parent 2:_____ DOB:_____/_____/_____

Married; Date: _____/_____/_____

Separated; Date_____/_____/_____ Divorced; Date _____/_____/_____

Siblings (1st to last):

Name: _____ Age:_____ Name: _____ Age: _____

Name: _____ Age:_____ Name: _____ Age: _____

Name: _____ Age:_____ Name: _____ Age: _____

People in household, if different from above: _____

_____

Was your child adopted by either parent? ☐ No ☐ Yes

If yes, the date you/they became caretaker: _____/_____/_____

Who is the primary caregiver for this child? _____

Does Parent 1 work outside of the home? ☐ No ☐ Yes

Occupation: _____ Hours per week:_____

Parent 1's highest level of education: _____

Does Parent 2 work outside of the home? ☐ No ☐ Yes

Occupation: _____ Hours per week:_____

Parent 2'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? ☐ No ☐ Yes

If yes, specify: _____

_____

_____

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

_____

_____

_____

Trauma History

Has your child been verbally abused? ☐ No ☐ Yes ☐ Suspected

Specify: _____

_____

Has your child been physically abused? ☐ No ☐ Yes ☐ Suspected

Specify: _____

_____

Has your child been sexually abused? ☐ No ☐ Yes ☐ Suspected

Specify: _____

_____

Other stressors or traumas? _____

_____

Check the symptoms your child/adolescent displays and list the number of times per week it is displayed:

How often?		How often?	
_____	☐Anger	_____	☐Has unusual sexual knowledge
_____	☐Anxiety	_____	☐Homicidal thoughts
_____	☐Acts out sexually	_____	☐Hyperactivity
_____	☐Bed wetting	_____	☐Hypervigilance
_____	☐Conduct problems	_____	☐Impaired conscience
_____	☐Controlling Defecation	_____	☐Isolation
_____	☐Day wetting	_____	☐Lack of empathy
_____	☐Defiance	_____	☐Lack of motivation
_____	☐Depression	_____	☐Lethargy
_____	☐Disassociates actions	_____	☐Low impulse control
_____	☐Drug or alcohol use	_____	☐Low self-esteem

_____☐Lying

_____☐Masturbates excessively

_____☐Nightmares

_____☐Obsesses

_____☐Over/Under eating

_____☐Plays out sexual themes

_____☐Plays out violent themes

_____☐Peer problems

_____☐Phobias

_____☐Running away

_____☐Shy

_____☐Sleeplessness

_____☐Somatic symptoms
(i.e. headaches/stomach aches, etc.)

_____☐Stealing

_____☐Tantrums

Other symptoms not listed:

_____

_____

How does your child/adolescent handle anger?

_____

_____

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

_____

_____

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

_____

_____

What are your child/adolescent’s hobbies?

_____

_____

What are your child/adolescent’s responsibilities at home?

_____

_____

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

_____

_____

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

_____

_____

_____

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

_____

_____

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 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.

_____ _____

Signature Date

Thank you