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:

Primary Caregiver: _____

Co-parent: _____

Child: _____

Parental Relationship: _____

Family History

Parent 1:_____ DOB:_____

Parent 2:_____ DOB:_____

___/___/___ Married; ___/___/___ Separated; ___/___/___ Divorced

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?: __Y, __N; If yes, the date you/they became caretaker: _____

Who is the primary caregiver for this child? _____

Does Parent 1 work outside of the home? __Y, __N; Occupation: _____ Hours:_____

Parent 1's highest level of education: _____

Does Parent 2 work outside of the home? __Y, __N; Occupation: _____ Hours:_____

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? __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/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: _____

_____

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 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.

_____

Signature Date