FOCUS FORWARD
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# Child and Adolescent Information Form

Today's Date __/ / Filled out by _____ Relationship to child _____

Child's Full Name _____

Birth date / / Age _____ Male ☐ Female ☐ Ethnicity/Race _____

Address _____
Street City State Zip Code

**Presenting problems**
What are your concerns about the child?

_____

_____

_____

How long has he/she had the problem(s)_____

**CURRENT SYMPTOM CHECKLIST** (Rate intensity of symptoms that are *currently* present)
0 = Symptom is not present at this time
1 = Symptom present, but not enough to be a problem.
2 = Mild impact on quality of life (child typically functions okay)
3 = Moderate impact on quality of life and/or day-to-day functioning
4 = Serious impact on quality of life and strongly interferes with day-to-day functioning

| Symptom | Severity | Symptom | Severity | Symptom | Severity |
|---|---|---|---|---|---|
| Alcohol problems | 0 1 2 3 4 | Stays out late/runs away | 0 1 2 3 4 | Sadness | 0 1 2 3 4 |
| Drug problems | 0 1 2 3 4 | Truant from school | 0 1 2 3 4 | Low self-esteem | 0 1 2 3 4 |
| Social/relational issues | 0 1 2 3 4 | Steals | 0 1 2 3 4 | Thoughts of death | 0 1 2 3 4 |
| Academic problems | 0 1 2 3 4 | Inattentive | 0 1 2 3 4 | Thoughts of harming self | 0 1 2 3 4 |
| Physically aggressive | 0 1 2 3 4 | Fidgets/squirms | 0 1 2 3 4 | Sleep problems | 0 1 2 3 4 |
| Verbally aggressive | 0 1 2 3 4 | Fails to finish things | 0 1 2 3 4 | Poor appetite | 0 1 2 3 4 |
| Bullies, threatens others | 0 1 2 3 4 | Difficulty playing quietly | 0 1 2 3 4 | Hears voices not there | 0 1 2 3 4 |
| Loses temper easily | 0 1 2 3 4 | Talks excessively | 0 1 2 3 4 | Sees things not there | 0 1 2 3 4 |
| Argues with adults | 0 1 2 3 4 | Is forgetful | 0 1 2 3 4 | Anxious/fearful | 0 1 2 3 4 |
| Defiant | 0 1 2 3 4 | Blurts out/interrupts others | 0 1 2 3 4 | Separation anxiety | 0 1 2 3 4 |
| Annoys others on purpose | 0 1 2 3 4 | Loses things | 0 1 2 3 4 | Physical complaints | 0 1 2 3 4 |
| Easily annoyed by others | 0 1 2 3 4 | Poor organization skills | 0 1 2 3 4 | Heart pounding/racing | 0 1 2 3 4 |
| Angry/irritable | 0 1 2 3 4 | Easily distracted | 0 1 2 3 4 | Unusual behaviors (explain): | 0 1 2 3 4 |
| Destructive to property | 0 1 2 3 4 | Low energy/fatigue | 0 1 2 3 4 | | |
| Lies (to avoid trouble) | 0 1 2 3 4 | Unpredictable Moods | 0 1 2 3 4 | | |

**EMOTIONAL/PSYCHIATRIC HISTORY**
Has your child been in counseling before? _____ No _____ Yes:

| Name of Counselor | Counselor Address | Counselor Phone No. | Dates of service | How many sessions? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Has your child ever been hospitalized for a psychiatric or substance use disorder? _____ No _____ Yes:

| Name of facility | City and state of facility | Facility phone number | Admission date | For how long? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Does your child take any medication(s)? _____ No _____ Yes If yes, what medication(s) and for which condition(s)? _____

_____

Has any family member used psychiatric medication(s)? _____ No _____ Yes If yes, who/what/why (list all): which condition(s)?

_____

Does your child have a history of physical or sexual abuse, neglect, witnessing domestic violence, trauma, prolonged separation, or abandonment? _____ No _____ Yes, If yes, please provide details of experience (including type, age of onset, duration, and any apparent trauma effects):

_____

_____

**Emotional health problems of family: (check all that apply)**

| | Mother | Father | Sister | Brother | Aunt | Uncle | Grandparents |
|---|---|---|---|---|---|---|---|
| Alcohol/drugs | | | | | | | |
| Anxiety | | | | | | | |
| Attention Deficit | | | | | | | |
| Bipolar Disorder | | | | | | | |
| Depression | | | | | | | |
| Eating Disorder | | | | | | | |
| Posttraumatic stress | | | | | | | |
| Schizophrenia | | | | | | | |
| Suicide attempt | | | | | | | |

**Family Relationships:**
List other adults and children living in the home:

| Name | Age | Gender | Relationship to Child | Quality of Relationship? |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | Good □ Fair □ Poor □ |
| _____ | _____ | _____ | _____ | Good □ Fair □ Poor □ |
| _____ | _____ | _____ | _____ | Good □ Fair □ Poor □ |
| _____ | _____ | _____ | _____ | Good □ Fair □ Poor □ |
| _____ | _____ | _____ | _____ | Good □ Fair □ Poor □ |

**Child's Development:**
Please indicate if any of the following occurred during the pregnancy and developmental period for your child:

| | | | If yes, please describe: |
|---|---|---|---|
| Medical problems during mother's pregnancy? | _____ No | _____ Yes | _____ |
| Poor/inadequate prenatal care? | _____ No | _____ Yes | _____ |
| Mother used drugs/alcohol/cigarettes during pregnancy? | _____ No | _____ Yes | _____ |
| Mother experienced unusual stress during pregnancy? | _____ No | _____ Yes | _____ |
| Labor or delivery problems? | _____ No | _____ Yes | _____ |
| Child had problems during the newborn period? | _____ No | _____ Yes | _____ |
| Developmental delays (walking, talking, toilet training, etc.)? | _____ No | _____ Yes | _____ |
| Poor temperament in early childhood? | _____ No | _____ Yes | _____ |

**Medical history**

Describe current health: [ ] Good [ ] Fair [ ] Poor

Name of personal physician: _____

Address: _____ Phone number: _____

Name of psychiatrist (if any) : _____

Address: _____ Phone number: _____

Date of last physical exam: _____

List any abnormal test results: _____

Describe any serious hospitalizations or accidents:

Date _____ Age _____ Reason _____

Date _____ Age _____ Reason _____

Date _____ Age _____ Reason _____

**School History:**

Child's school _____ Grade _____

| Does/has your child… | | | If yes, please describe: |
|---|---|---|---|
| have learning problems? | _____ No | _____ Yes | _____ |
| have behavior problems in school? | _____ No | _____ Yes | _____ |
| have social problems in school? | _____ No | _____ Yes | _____ |
| receive special help in school? | _____ No | _____ Yes | _____ |
| ever been held back a grade? | _____ No | _____ Yes | _____ |
| have other school problems? | _____ No | _____ Yes | _____ |

Is it ok to contact school staff about child? _____ No _____Yes: Teacher/Staff _____

School Address _____ Phone _____
Street City State Zip Code

**Please write down anything else you think we should know:**

_____

_____

_____

_____

_____

_____

_____

_____