YOU-Turn Counseling, PLLC

Child and Adolescent Information and Assessment

Child's Name: _____ Date of Birth _____

Age_____ Male_____ Female _____ Non-Binary _____

Address_____ City_____Zip_____

Home Phone_____ Alt Phone _____

Current School _____ City _____

Current Grade _____ Teacher Name _____

Ethnicity: ☐ Caucasian ☐ African American ☐ Asian-Pacific Islander
☐ Hispanic-Latino ☐ Other: Specify _____

Household Members:

Name	Age	Relationship to Client

Father's Name _____ Date of Birth _____

Address (if different)_____ City_____ Zip_____

Home Phone_____ Cell Phone _____

Email Address: _____

Mother's Name _____ Date of Birth _____

Address (if different)_____ City_____ Zip_____

Home Phone_____ Cell Phone _____

Email Address: _____

How were you referred to us? _____

Optional Information for Statistical Purposes Only:

Total Family Annual Income (Gross) _____per ☐ Month ☐ Year

Religious preference_____

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Reason for Seeking Help

Why have you brought your child for counseling? _____

_____

_____

How would you rate the seriousness of your present situation? (1-10)

(1 meaning not serious and increasing in severity up to 10, meaning extremely serious)

Now _____6 months ago _____Year ago _____

Mental Health and Life Stress Inventory

Please circle any area where you have concerns regarding your child:

Anxiety/ Nervousness/Panic	Alcohol or Drug use in Child or Family
Anger/Irritability	Childhood Abuse or Neglect
Witness Domestic Violence	Depression
Difficulty Making Decision	Excessive Worry/ Stress
Financial Concerns	Gambling
Guilt/Feelings of Worthlessness	Grief/Loss
Impaired Memory/ Poor Concentration	Interpersonal Relationships
Legal Matters	Loss of Interest or Pleasure in Things
Mood Changes	Pain
Sexual Problems	Self Esteem
Sexual Assault/Rape	Sleeping Problems
Thoughts of Suicide/Death	Change in Appetite
Thoughts of Homicide	Weight Loss/Gain

Has either parent ever abused alcohol or drugs? ☐ No ☐ Yes If yes, please explain below:

_____

_____

Has the child/adolescent experienced a problem with drinking or drugs? ☐ No ☐ Yes If yes, please explain below:

_____

_____

What other background/concerns/events could be important to know? _____

_____

Health History

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Has your child ever been treated for the following?
Circle all that apply

Allergies	Diabetes	High Blood Pressure
Asthma	Emotional Problems	HIV/AID
Seizure Disorder	Stomach Problems	Cancer
Pain or Headaches	Head/Brain Injury	Heart Disease

Disabilities: ☐ Physical Disability ☐ Developmental ☐ Visual/Hearing Impaired
☐ Mental Illness ☐ Other (Specify): _____

List any health problems: _____

_____

Is your child currently under the care of a physician or psychiatrist for any physical or emotional conditions? ☐ Yes ☐ No If Yes, list physician's name and the reason for treatment

_____

Prior Counseling:

Name of Clinician	Year and Length of Treatment

Name of current physician: _____
Phone Number of current physician: _____
Please List any medication presently taking: _____
_____

Previous Hospitalizations (Dates and Reasons): _____

_____

Are you or your child presently involved in any litigation? If yes, please explain: _____

_____

Who may we contact in case of an emergency?

Name: _____ Name: _____

Phone Number: _____ Phone Number: _____

Relationship: _____ Relationship: _____

_____ _____

PARENT/ LEGAL GUARDIAN SIGNATURE **DATE**