North Gwinnett Counseling Associates, LLC
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Child/Adolescent Information Form

(Revised December 2008)

This Form is Completely Confidential

Today's date: _____

Client's name: _____
Last **First** **Middle Initial**

Name Preferred to be called:_____

Date of birth: _____ Gender**:** _____ Social **Security #:** _____
Age:_____
Mother's Name: _____ **Home Phone:** _____

Cell Phone: _____ **Email:** _____

Father's Name: _____ **Home Phone:** _____

Cell Phone: _____ **Email:** _____

Calls will be discreet, but please indicate any restrictions: _____
_____

Parents' marital status: Married Divorced Separated Never Married Living Together

Who is the child's primary caretaker? _____

Who has Legal Custody of the Child? _____
(*Please provide a copy of any legal custody agreements. Required to verify consent to treat.)

Referred by: _____

- May I have your permission to thank this person for the referral?
  ☐ **Yes** ☐ **No**
- If referred by another clinician, would you like for us to communicate with one another?
  ☐ **Yes** ☐ **No**

Person(s) to notify in case of any emergency: _____
Name **Phone**

We will only contact this person if we believe it is a life or death emergency. Please provide your signature to indicate that we may do so. (Your Signature): _____

SCHOOL INFORMATION

School Name: _____

(office use)_____

_____

_____

FAMILY INFORMATION:

Who lives in the home with your child? _____

How does your child get along with family members? _____

Do any blood relatives to the child have any mental health or substance abuse problems?

YOUR CHILD:

What are your child's strengths? _____

What does your child like to do for fun? _____

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses): _____

Current Medications (if you need more room, please write on the back of this page**:**

Doctor: _____ Phone Number: _____

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous medical hospitalizations (Approximate dates and reasons): _____

Previous psychiatric hospitalizations (Approximate dates and reasons): _____

Has your child ever talked with a counselor or psychiatrist? YES NO
(Please list approximate dates and reasons): _____

PLEASE CHECK ALL THAT APPLY & ***CIRCLE*** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST
Anxiety →				People in General →				Nausea →		
Depression				Parents				Abdominal Distress		
Mood Changes				Siblings				Fainting		
Anger or Temper				Friendship				Dizziness		
Panic				Friend(s)				Diarrhea		
Fears				Co-Worker(s)				Shortness of Breath		
Irritability				Employer				Chest Pain		
Concentration				Finances				Lump in the Throat		
Headaches				Legal Problems				Sweating		
Loss of Memory				Sexual Concerns				Heart Palpitations		
Excessive Worry				History of Child Abuse				Muscle Tension		
Feeling Manic				History of Sexual Abuse				Pain in joints		
Trusting Others				Domestic Violence				Allergies		
Communicating with Others				Thoughts of Hurting Someone Else				Often Make Careless Mistakes		
Drugs				Hurting Self				Fidget Frequently		
Alcohol				Thoughts of Suicide				Speak Without Thinking		
Caffeine				Sleeping Too Much				Waiting Your Turn		
Frequent Vomiting				Sleeping Too Little				Completing Tasks		
Eating Problems				Getting to Sleep				Paying Attention		
Severe Weight Gain				Waking Too Early				Easily Distracted by Noises		
Severe Weight Loss				Nightmares				Hyperactivity		
Blackouts				Head Injury				Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems				Physical Abuse				Depression		
Legal Trouble				Sexual Abuse				Anxiety		
Domestic Violence				Hyperactivity				Psychiatric Hospitalization		
Suicide				Learning Disabilities				"Nervous Breakdown"		

Any additional information you would like to include:

_____

_____