CLIENT INFORMATION SCREENING INDIVIDUALS UNDER 18 YRS OF AGE Name of person completing form: _____ Relationship to client: _____	Client's Name (Last, First , M.I.): D.O.B.:

1. IDENTIFYING INFORMATION (for client)

Name of Parent/Guardian Residing at address below:
Address:
City: State: Zip Code:
Telephone (Day): Telephone (Evening):
Can we call you at work? ❑ Yes ❑ No
If you have no phone, where can we leave a message? Name: Telephone:
Emergency Contact: Name: Relationship: Telephone:

2. FAMILY HISTORY OF CHILD/ADOLESCENT

	NAME	SEX	AGE	Lives with Client	
				Yes	No
CLIENT					
MOTHER					
FATHER					
SIBLINGS:					
Others in the household (e.g., step parents, grandparents, etc.)					

CLIENT'S NAME:

3. PRIOR TREATMENT/COUNSELING HISTORY OF CHILD/ADOLESCENT

Type	Yes	No	When	Where	Did you find it helpful?
Counseling/Therapy					❑ Yes ❑ No
Drug/Alcohol					❑ Yes ❑ No
12 Step Program					❑ Yes ❑ No
Psychiatric Hospital					❑ Yes ❑ No

4. PHYSICAL HEALTH OF CHILD/ADOLESCENT

Date last seen by M.D.:

Reason for visit:

Name of your child's current physician:

Address: Telephone #:

Please identify any major health problems your child has had in the past and specify if this problem is still present.

Is your child's immunization current? ❑ Yes ❑ No

Has your child had a tuberculin test? ❑ Yes ❑ No

Has your child ever had an eye exam? ❑ Yes ❑ No Results:

Has your child ever had a hearing exam? ❑ Yes ❑ No Results:

Has your child experienced injuries, hospitalizations? ❑ Yes ❑ No If yes, please explain:

Current medications:

Is your child allergic to any medications or drugs? Describe:

Family history of major medical problems:

CLIENT'S NAME: _____

FOR GIRLS ONLY:

Menstrual period: Age of onset: _____ Problems: _____

_____

Pregnancies? ❑ Yes ❑ No Abortions? ❑ Yes ❑ No If yes, number: _____

5. BEHAVIORAL ISSUES

Please check (✓) any of the following that are typical of the child's behavior:

( ) Shy	( ) Angry Defiant	( ) Slow Moving
( ) Worries	( ) Quarrels	( ) Difficult Sleep
( ) Moody	( ) Bullies	( ) Sleepwalking
( ) Sad, Cries	( ) Temper Tantrums	( ) Bed Wetting
( ) Loner	( ) Lies Frequently	( ) Soiling
( ) Expects Failure	( ) Destructive	( ) Poor Appetite
( ) Selfish	( ) Steals	( ) Weight Loss
( ) Lazy	( ) Sets Fires	( ) Overweight
( ) Avoids Adults	( ) Drug/Alcohol Use	( ) Often Ill
( ) Sexual Acting Out	( ) Frequent Headaches	( ) Unusual Thinking
( ) Police Problems	( ) Stomachaches	( ) Bizarre Behavior
( ) Tics or Twitch	( ) Messy	( ) Blinking, Jerking
( ) Easygoing	( ) Careless, Reckless	( ) Seizures
( ) Friendly	( ) Short Attention Span	( ) Speech Problems
( ) Enthusiastic	( ) Frequent Daydreams	( ) Learning Problems
( ) Confident	( ) Overactive	( ) Cooperative
( ) Acts Without Thinking	( ) Sloppy Hygiene	( ) Generous
( ) Suicide Gesture	( ) Clumsy	( ) Frequent Injuries
( ) Other	( ) Suicide Attempt	( ) Psychiatric Problems

Signature of Person Completing Form: _____ Date: _____

Therapist Signature: _____ Date: _____