

## Evergreen Behavioral Health Child/Adolescent Client Information Form

Please provide the following information about the child or adolescent seeking treatment. This information will help me to better understand your needs and concerns, and develop an appropriate treatment plan. If there are any items you are uncomfortable answering, leave them blank and we can discuss them further during our session.

### Client Identification and Contact Information

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Home Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ School Grade: \_\_\_\_\_

OK to send mail?  Yes  No

### Phone Numbers

Home Phone: \_\_\_\_\_

OK to leave message?  
 Yes  No

Cell/Mobile Phone: \_\_\_\_\_

Yes  No

### Family Contact Information *Please provide information about all adults who have a parent/guardian role, including step-parents, partners, and/or grandparents.*

Name: \_\_\_\_\_ Relationship to Above Client: \_\_\_\_\_

Home Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

OK to leave message?

Home Phone: \_\_\_\_\_

Yes  No

Cell/Mobile Phone: \_\_\_\_\_

Yes  No

Name: \_\_\_\_\_ Relationship to Above Client: \_\_\_\_\_

Home Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

OK to leave message?

Home Phone: \_\_\_\_\_

Yes  No

Cell/Mobile Phone: \_\_\_\_\_

Yes  No

Name: \_\_\_\_\_ Relationship to Above Client: \_\_\_\_\_

Home Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

OK to leave message?

Home Phone: \_\_\_\_\_

Yes  No

Cell/Mobile Phone: \_\_\_\_\_

Yes  No

Name: \_\_\_\_\_ Relationship to Above Client: \_\_\_\_\_

Home Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

OK to leave message?

Home Phone: \_\_\_\_\_

Yes  No

Cell/Mobile Phone: \_\_\_\_\_

Yes  No

### Emergency Contact Information

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

**Referral Information**

Who gave you my name to call? \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

May I contact this person to thank them for the referral?  Yes  No

**Primary Concern**

Please describe the main reason you are seeking therapy: \_\_\_\_\_

\_\_\_\_\_

What would you like to get out of coming to therapy? \_\_\_\_\_

\_\_\_\_\_

**Symptoms**

*Please check all of the issues that you are experiencing currently (or in the past month):*

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Hard time focusing          | <input type="checkbox"/> Panic attacks              | <input type="checkbox"/> Anxiety/Worry                  |
| <input type="checkbox"/> Poor memory/forgetful       | <input type="checkbox"/> Social discomfort          | <input type="checkbox"/> Eating problems                |
| <input type="checkbox"/> Sadness/Depression          | <input type="checkbox"/> Perfectionism              | <input type="checkbox"/> Problems with pornography      |
| <input type="checkbox"/> Loss of Pleasure/Interest   | <input type="checkbox"/> Obsessive thoughts         | <input type="checkbox"/> Academic problems              |
| <input type="checkbox"/> Hopelessness                | <input type="checkbox"/> Compulsive behavior        | <input type="checkbox"/> Relationship problems          |
| <input type="checkbox"/> Guilt/Shame                 | <input type="checkbox"/> Aggression/Fights          | <input type="checkbox"/> Difficulty completing homework |
| <input type="checkbox"/> Thoughts of death/self harm | <input type="checkbox"/> Frequent arguments         | <input type="checkbox"/> Alcohol/Drug use               |
| <input type="checkbox"/> Thoughts of hurting others  | <input type="checkbox"/> Irritability/Anger         | <input type="checkbox"/> Legal matters                  |
| <input type="checkbox"/> Self harm behaviors         | <input type="checkbox"/> Flashbacks                 | <input type="checkbox"/> School behavior problems       |
| <input type="checkbox"/> Change in appetite          | <input type="checkbox"/> Hearing voices             | <input type="checkbox"/> Medical/health problems        |
| <input type="checkbox"/> Lack of motivation          | <input type="checkbox"/> Seeing things others can't | <input type="checkbox"/> Financial problems             |
| <input type="checkbox"/> Crying spells               | <input type="checkbox"/> Suspicion/Paranoia         | <input type="checkbox"/> Computer addiction             |
| <input type="checkbox"/> Loneliness                  | <input type="checkbox"/> Racing thoughts            | <input type="checkbox"/> Gambling problems              |
| <input type="checkbox"/> Low self-worth              | <input type="checkbox"/> Excessive energy           | <input type="checkbox"/> _____                          |
| <input type="checkbox"/> Guilt/Shame                 | <input type="checkbox"/> Wide mood swings           | <input type="checkbox"/> _____                          |
| <input type="checkbox"/> Chronic fatigue/low energy  | <input type="checkbox"/> Sleeping problems          | <input type="checkbox"/> _____                          |
| <input type="checkbox"/> Withdrawal from others      | <input type="checkbox"/> Nightmares                 | <input type="checkbox"/> _____                          |

To the best of your knowledge, when did current problems begin? \_\_\_\_\_

Do you have any ideas regarding what may be contributing to these problems? \_\_\_\_\_

Do you have any history of attempting to harm yourself or others? If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Therapist Notes (Office Use Only): \_\_\_\_\_

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**Previous Mental Health Treatment**

Have you received previous psychological, psychiatric, drug and alcohol, or counseling/therapy services?

Yes  No If yes, please describe:

When	From Whom	For What	Results

Have you ever taken medications for psychiatric or emotional problems?  Yes  No

If yes, please describe:

When	From Whom	For What	Results

**Family History**

	Name	Relationship Quality	Age	Live with?
Mother				
Father				
Siblings				
Step-Parent				
Step-Parent				
Grandparent				
Grandparent				

Have any of your family members experienced the following?	If yes, who?
ADD/ADHD	
Anxiety	
Depression	
Manic Depression/ Bipolar	
Schizophrenia	
Substance Abuse	
Suicide	

Have you experienced any of the following:

- Violence in the home
- Parent substance abuse
- Parent death/illness
- Time in foster care
- Homelessness
- Financial problems
- Multiple family moves
- Neglect
- Physical/Sexual Abuse
- Emotional Abuse
- Parents permanently separated or divorced
- Loss of a loved one

Is there anything else you would like me to know about your family background at this time? \_\_\_\_\_

Therapist Notes (Office Use Only):

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**Substance Abuse**

Do you currently consume alcohol? Yes No

If yes, how much and how often: \_\_\_\_\_

Do you currently use non-prescribed drugs or street drugs? Yes No

If yes, how much and how often: \_\_\_\_\_

Have you ever experienced problems with the law, relationships, or work/school functioning due to your drug use? Yes No

**School Information**

Current school: \_\_\_\_\_ Current grade/placement: \_\_\_\_\_

Main contact at school: \_\_\_\_\_ School Phone: \_\_\_\_\_

This year's school grades  Excellent  Good  Fair  Poor

This year's school behavior:  Excellent  Good  Fair  Poor

Past school grades:  Excellent  Good  Fair  Poor

Past school behavior:  Excellent  Good  Fair  Poor

Do you have concerns about any of the following?

- Incomplete homework  Learning problems  Attendance problems
- Poor grades  Teased or bullied  Child dislike of teacher
- Skipped grade  Repeated Grade  Conflict between family and school
- On IEP  Suspension  Referrals / detentions

Do you have any other concerns about your child or adolescent's school experience: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Strengths, Interests, and Social Support**

Please describe your child or adolescent's social support network:

- Family  Community Group: \_\_\_\_\_  Friends
- Neighbors  Religious/Spiritual Group: \_\_\_\_\_  Other: \_\_\_\_\_

Would you like your religious/spiritual beliefs to be incorporated into therapy? Yes No

Please describe any special skills, talents, hobbies or strengths: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Therapist Notes (Office Use Only): \_\_\_\_\_  
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**Medical Information**

Has your child experienced any of the following:

	Past	Present	Details
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	
Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Speech/Language Delay	<input type="checkbox"/>	<input type="checkbox"/>	
Poor coordination	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental Delays	<input type="checkbox"/>	<input type="checkbox"/>	
Bedwetting/Toileting Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Headaches	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Head Injury/Loss of Consciousness	<input type="checkbox"/>	<input type="checkbox"/>	
Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	
Other Serious Injury	<input type="checkbox"/>	<input type="checkbox"/>	
Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	
Serious Illness/Fevers	<input type="checkbox"/>	<input type="checkbox"/>	
Pre-natal drug/alcohol exposure	<input type="checkbox"/>	<input type="checkbox"/>	
Pre-natal/delivery problems	<input type="checkbox"/>	<input type="checkbox"/>	

Please list any current medications or over the counter drugs you are taking:

Medication	Reason for Taking	Who is it prescribed by?	How long have you been taking this medication?

**Primary Care Physician**

Doctor's Name: \_\_\_\_\_  
 Clinic Name: \_\_\_\_\_  
 Address: \_\_\_\_\_

Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_

Therapist Notes (Office Use Only): \_\_\_\_\_

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\_\_\_\_\_