Wright Counseling Group
662-202-7332

Child/Adolescent Information Sheet

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Child's Name: _____ Date:_____

Birth date: _____/_____/_____ Age: _____ Gender _____

Address: _____

City, State: _____ Zip: _____

Parent/ Guardian Name(s): _____

Home Phone: (____)_____ May I leave a message? □Yes □No

Cell/Other Phone: (____)_____ May I leave a message? □Yes □No

E-mail: _____ May I email you? □Yes □No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

School:_____ Phone:_____ Teacher:_____ Grade: _____

How does your child do in school academically? _____

How does your child do in school behaviorally?_____

Does your child have a learning or physical disability? __Y, __N, __Maybe. Specify: _____

_____

Does your child have a mental health diagnosis? __Y, __N, Specify: _____

_____

Does your family have specific spiritual beliefs? _____

Medical History

During pregnancy, did mother use: __ Cigarettes, __ Alcohol, __ Drugs, __ Experience Extreme Stress?

Specify frequency, amounts, and duration: _____

List any birth complications (Ex: Premature, jaundice, C-section, etc.)_____

_____

List any Medical conditions or history (Ex: Surgeries, broken bones, allergies, etc.)_____

_____

Does child use: __ Cigarettes, __ Alcohol, __ Drugs

Specify amount and frequency: _____

Primary Care Physician: _____ Phone:_____ Last seen on: _____

Psychiatrist: _____ Phone:_____ Last seen on: _____

Current medications: (Include dosage and frequency):_____

_____

Medication Allergies: _____

Other Allergies: _____

In the first two years, did your child experience: __Separation from mother __Out of home care, __Disruption in bonding __Depression of mother __Abuse __Neglect __Chronic pain __Chronic Illness __Parental Stress

If yes, please specify: _____

_____

Reached developmental milestones: __On time, __Early, __Late

How many times has the child moved homes? _____

What are five adjectives that describe:

Primary Caregiver: _____

Co-parent: _____

Child: _____

Parental Relationship: _____

Family History

Parent 1:_____ DOB:_____

Parent 2:_____ DOB:_____

___/___/___ Married; ___/___/___ Separated; ___/___/___ Divorced

Siblings (1st to last):
Name: _____ Age:____ Name: _____ Age: ____

Name: _____ Age:____ Name: _____ Age: ____

Name: _____ Age:____ Name: _____ Age: ____

People in household, if different from above: _____

_____

Was your child adopted by either parent?:__Y, __N; If yes, the date you/they became caretaker: _____

Who is the primary caregiver for this child? _____

Does Parent 1 work outside of the home? __Y, __N; Occupation: _____ Hours:_____

Parent 1's highest level of education: _____

Does Parent 2 work outside of the home? __Y, __N; Occupation: _____ Hours:_____

Parent 2's highest level of education: _____

If separated or divorced, visitation schedule: _____

What is custody arrangement regarding physical and mental health care: _____

_____

Does either parent have legal issues? _____

List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety,

bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.): _____

_____

_____

Have children witnessed domestic violence? __Y, __N, Specify: _____

_____

How is your child disciplined? Please list each method and frequency of use: _____

_____

_____

Trauma History

Has your child been verbally abused? __Y, __N, __Suspected. Specify: _____

_____

Has your child been physically abused? __Y, __N, __Suspected. Specify: _____

_____

Has your child been sexually abused? __Y, __N, __Suspected. Specify: _____

_____

Other stressors or traumas? _____

_____

Circle the symptoms your child/adolescent displays and list the number of times per week it is displayed:

Anger	Anxiety	Bed wetting
Acts out sexually	Conduct problems	Controlling Defecation
Has unusual sexual knowledge	Day wetting	Defiance
Depression	Homicidal thoughts/ actions	Disassociates
Drug or alcohol use	Hyperactivity	Masturbates excessively
Hyper vigilance	Impaired conscience	Isolation
Lack of empathy	Lack of motivation	Lethargy
Low impulse control	Plays out violent themes	Low self-esteem
Lying	Nightmares	Plays out sexual themes
Obsesses	Over/Under eating	Phobias
Peer problems	Phobias	Running Away
Shy	Sleeplessness	Stealing
Tantrums	Somatic Symptoms: Headaches/Stomachaches, etc.	

Other: _____

_____

How does your child/adolescent handle anger? _____

_____

Has the child/adolescent experienced any significant loss? If yes, explain: _____

_____

What do you view as your child/adolescent ’s major strengths and positive traits?_____

_____

What are your child/adolescent's hobbies? _____

_____

What are your child/adolescent's responsibilities at home? _____

_____

How well does your child/adolescent's handle these responsibilities? _____

_____

Briefly describe your goals for your child/adolescent's therapy: _____

_____

_____

Please list any information you deem to be important for the therapist to know: _____

_____

_____

_____

Who shall I contact in case of emergency?
Name: _____

Phone (_____)_____ Relationship _____

In this box, please indicate the address and telephone number you want me to use to when sending bills or when I need to contact you. If this box is left blank, I will use the address and any of the telephone numbers you have provided above. If you do *not* want me to leave a message on your answering machine, please tell me how you want me to reach you by phone:

I hereby consent for Wright Counseling Group to treat my child within the context of family therapy.

_____

Signature Date

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable) Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries. I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____

Client Signature

_____ Today's Date

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full fee of is charged for missed appointments or no show cancellations with less than a 24 hour notice unless due to illness or an emergency.

Thank you for your consideration regarding this important matter.

_____

Client Signature

_____ Today's Date