Family Counseling & Psychology Center, P.C.

2485 Tech Drive
Bettendorf, Iowa 52722
Phone: 563-355-1611 Fax: 563-355-6617

Child/Adolescent Contact Information

Client Name: _____ Date: _____

Legal Name (if different): _____ Date of Birth: _____

Address: _____ Gender: ☐ M ☐ F ☐ TG

City: _____ State: _____ Zip: _____ Age: _____

Social Security #: _____

Insurance Information:

Primary Health Insurance: _____ Subscriber Name: _____

Relationship to Subscriber: _____ Subscriber Date of Birth: _____

ID Number: _____ Group/Policy #: _____

Type of Coverage: ☐ Secondary ☐ EAP (Employee Assistance Program)

Additional Health Insurance: _____ Subscriber Name: _____

Relationship to Subscriber: _____ Subscriber Date of Birth: _____

ID Number: _____ Group/Policy #: _____

Financial Guarantor (Financially Responsible Person) Information:

Name: _____ Relationship: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Signature: _____

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Name: _____ D.O.B._____ ID #_____

Contact Information:

Please complete information and check boxes below where relevant or available

Legal Guardian? Phone Messages Ok?

☐ Mother's Name: _____
Home Phone: ( )_____ ☐ Yes ☐ No
Work Phone: ( )_____ ☐ Yes ☐ No
Cell Phone: ( )_____ ☐ Yes ☐ No

☐ Father's Name: _____
Home Phone: ( )_____ ☐ Yes ☐ No
Work Phone: ( )_____ ☐ Yes ☐ No
Cell Phone: ( )_____ ☐ Yes ☐ No

☐ Step-Mother's Name: _____
Contact #: ( ) _____ ☐ Yes ☐ No

☐ Step-Father's Name: _____
Contact #: ( ) _____

☐ Non Parent Legal Guardian's Name: _____
Relationship to Youth: _____ ☐ Yes ☐ No
Contact #: ( ) _____
Youth (client)
Contact #: ( ) _____ ☐ Yes ☐ No

Who should receive reminder Calls:

Name: _____ Relationship:_____
Phone: _____ ☐ Call ☐ Text ☐ Email: _____

Emergency Contact Information (other than the people noted above)

Name: _____ Home Phone ( ) _____
Work Phone ( ) _____ Cell Phone ( ) _____
Relationship to Child: _____

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Name: _____ D.O.B._____ ID #_____

Primary Care Physician Information

Current Physician: _____
Physician Address: _____
Physician Phone: _____

School Information

Current School: _____ Primary Teacher's Name: _____
Main Contact at School: _____ School Phone # _____

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Name: _____ D.O.B._____ ID #_____

Presenting Problems and Concerns

Describe the problem that brought you here today: _____

_____

Please check all your child's behaviors and symptoms that you consider problematic:

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor Memory/Confusion
- ☐ Sadness/Depression
- ☐ Hopelessness
- ☐ Thoughts of death
- ☐ Self-harm behaviors
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self worth
- ☐ Fatigue
- ☐ Recurring, disturbing memories
- ☐ Change in appetite
- ☐ Withdrawal from people
- ☐ Anxiety/worry
- ☐ Panic attacks
- ☐ Fear away from home
- ☐ Social discomfort
- ☐ Phobias
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Racing thoughts
- ☐ Wide mood swings
- ☐ Suspicion/paranoia
- ☐ Hearing voices
- ☐ Visual hallucinations
- ☐ Defiance
- ☐ Aggression/fights
- ☐ Homicidal thoughts
- ☐ Frequent arguments
- ☐ Irritability/anger
- ☐ Peer/sibling conflict
- ☐ Stealing
- ☐ Destroys property
- ☐ Running away
- ☐ Swearing
- ☐ Curfew violations
- ☐ Lying
- ☐ Manipulative behavior
- ☐ No/few friends
- ☐ Eating problems
- ☐ Sleep problems
- ☐ Nightmares
- ☐ Toileting problems
- ☐ Fire setting
- ☐ Work/school problems
- ☐ Legal problems
- ☐ Sexual behavior
- ☐ Computer addiction
- ☐ Alcohol/drug use
- ☐ Lack of motivation
- ☐ Other: _____
- ☐ Viewing Pornography

Are your child's problems affecting any of the following?

☐ Handling everyday tasks ☐ Self esteem ☐ Relationships ☐ Hygiene ☐ Health
☐ Recreational activities ☐ Work/School ☐ Housing ☐ Legal Matters ☐ Finances

Has your child ever had thoughts, made statements, or attempted to hurt him/herself? ☐ Yes ☐ NO
If yes, please describe: _____

If yes to the above.....

- How often does your child have these thoughts? _____
- When was the last time they had these thoughts of dying? _____
- Has anything happened recently to make them feel this way? _____

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Name: _____ D.O.B._____ ID #_____

- On a scale of 1 to 10 (ten being strongest) how strong is their desire to kill themselves currently? __
- Would anything make it better? _____
- Have they ever thought about how they would kill yourself? _____
- Is the method they would use readily available? _____
- Have they planned a time for this? _____
- Is there anything that would stop them from killing yourself? _____
- Do they feel hopeless and/or worthless? _____
- Have they ever tried to kill or harm themselves before? _____
- Do they have access to guns? _____ If yes, please explain _____

Has your child ever had thoughts, made statements, or attempted to hurt someone else? ☐ Yes ☐ No
If yes, please describe: _____
_____

If yes to the above……

- How often does your child have these thoughts? _____
- On a scale of 1 to 10 (ten being strongest) how strong is their desire to kill someone else currently?
- Have they ever thought about how they would kill someone else? _____
- Is the method they would use readily available? _____
- Have they planned a time for this? _____
- Do they feel hopeless and/or worthless? _____
- Have they ever tried to kill or harm someone else before? _____
- Do you have access to guns? _____ If yes, please explain _____

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Name: _____ D.O.B._____ ID #_____

Has your child recently been physically hurt or threatened by someone else? ☐ Yes ☐ No

If yes, please describe: _____

_____

Therapist Notes:

Please list information regarding family relationships.

Relationship	Name	Live with Child	Age	Quality of Relationship
Mother				
Father				
Stepmother				
Stepfather				
Siblings				
Other relatives				

Please note if any family members have experienced any of the following mental health problems

Family Mental Health History	Who
Hyperactivity/ADHD	
Experienced Sexual Abuse	
Depression	
Bipolar Disorder	
Made Suicide Attempt	
Anxiety Problems	
Panic Attacks	
Obsessive-Compulsive Behavior	
Anger Problems/Abusive Behavior	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	
Autism	
Other	

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Name: _____ D.O.B._____ ID #_____

☐ Parents legally married or living together ☐ Mother remarried Number of times _____
☐ Parents temporarily separated ☐ Father remarried Number of times _____
☐ Parents divorced or permanently separated

Please check if your child has experienced any of the following types of trauma or loss:

☐ Emotional abuse ☐ Neglect ☐ Lived in a foster home
☐ Sexual abuse ☐ Violence in the home ☐ Multiple family moves
☐ Physical abuse ☐ Crime victim ☐ Homelessness
☐ Parent substance abuse ☐ Parent illness ☐ Loss of a loved one
☐ Teen pregnancy ☐ Placed a child for adoption ☐ Financial problems

Were there any medical problems during the pregnancy or birth of your child? ☐ Yes ☐ No
If yes, please describe: _____

_____

Did the biological mother use any tobacco, medication, street drugs, or alcohol while pregnant with this child? ☐ Yes ☐ No
If yes, please describe: _____

_____

Did your child have any developmental delays in early childhood (crawling, walking, talking, toileting, etc.)? ☐ Yes ☐ No
If yes, please describe: _____

_____

Therapist Notes:

Previous Mental Health Treatment

Yes	No	Type of Treatment	When?	Provider/Program	Reason for treatment
		Outpatient Counseling			
		Medication (mental health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-help/Support Groups			

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Name: _____ D.O.B._____ ID #_____

School Information:

Current grade/placement: _____

	Name of School	Excellent	Good	Fair	Poor
Elementary School Grades					
Elementary School Behavior					
Middle School Grades					
Middle School Behavior					
High School Grades					
High School Behavior					

Has your child had any of the following difficulties at school?

☐ Suspension
☐ Poor grades
☐ Gang influence
☐ Incomplete homework
☐ Teased or picked on
☐ School refusal
☐ Learning problems
☐ Speech problems
☐ Referrals or detentions
☐ Attendance problems

Does your child have an after-school provider? ☐ Yes ☐ No If so who? _____

Has your child ever repeated or skipped a grade? ☐ Yes ☐ No If so which one(s) _____

Has your child ever received Special Education services? ☐ Yes ☐ No
If yes, please describe service received and reason for services: _____

_____

Therapist Notes:

Family Counseling & Psychology Center, P.C.

Name: _____ D.O.B._____ ID #_____

Substance Use History (for ages 12 and older or if applicable)

- Tobacco
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____
- Caffeine
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____
- Alcohol
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____
- Marijuana
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____
- Cocaine/Crack
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____
- Ecstasy
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____
- Heroin
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____
- Inhalants
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____
- Methamphetamines
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____
- Pain Killers
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____
- PCP/LSD
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____
- Steroids
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____
- Tranquilizers
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____

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Name: _____ D.O.B._____ ID #_____

Has your child had withdrawal symptoms when trying to stop using any substances? ☐ Yes ☐ No
If yes, please describe: _____

Has your child gambled in the past 6 months? ☐ Yes ☐ No If yes, let us know the following:
Has your child ever felt the need to bet more and more money? ☐ Yes ☐ No
Has your child ever had to lie to people important to you about how much you gambled? ☐ Yes ☐ No

Has your child ever had problems with work, relationships, health, the law, etc. due to your substance use? ☐ Yes ☐ No
If yes, please describe: _____

How much time per day does your child spend:
Playing Video Games: _____
Watching Television: _____
Using a Computer: _____
Using a Mobile Device: _____

Does your child have unrestricted access to the internet? ☐ Yes ☐ No

Therapist Notes:

Medical Information

Date of last physical exam: _____

Has your child experienced any of the following medical conditions during his/her lifetime?

☐ Allergies	☐ Surgery	☐ Seizures	☐ Ear infections
☐ Chronic Pain	☐ Meningitis	☐ Hearing problems	☐ Sexually transmitted disease
☐ Dizziness/Fainting	☐ Diabetes	☐ Sleep disorder	☐ Other: _____
☐ High Fevers	☐ Abortion	☐ Stomach Aches	
☐ Miscarriage	☐ Headaches	☐ Head Injury	
☐ Asthma	☐ Serious Accident	☐ Vision problems	

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Name: _____ D.O.B._____ ID #_____

Personal and Family Medical History:

	Yes	No	Which Family Member
Thyroid Disease			
Anemia			
Liver Disease			
Chronic Fatigue			
Kidney Disease			
Stomach or intestinal problems			
Cancer (type)			
Fibromyalgia			
Heart Disease			
Chronic Pain			
High Cholesterol			
High Blood Pressure			
Liver Problems			
Other			

Please list any CURRENT health concerns: _____

_____

_____

Past medical problems, surgeries, or non psychiatric hospitalization: _____

_____

_____

Add additional personal or family history: _____

_____

_____

Current prescription medications: ☐ None

Medication	Dosage	Date First Prescribed	Prescribed By	Taken For

Current over-the-counter medications or supplements (including vitamins, herbal remedies, etc.):

_____

_____

_____

Allergies and/or adverse reactions to medications: ☐ None

If yes, please list: _____

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Therapist Notes:

Please describe your child's social support network (check all that apply):

☐ Family ☐ Neighbors ☐ Friends ☐ Students ☐ Co-workers

☐ Support/Self-Help Group ☐ Community Group ☐ Religious/Spiritual Center (which one)_____

To which cultural or ethnic group does your child belong? _____

_____

If your child is experiencing any difficulties due to cultural or ethnic issues, please describe : _____

_____

How important are spiritual matters to your child? ☐ Not at all ☐ Little ☐ Somewhat ☐ Very Much

Would you like spiritual/religious beliefs to be incorporated into your child's counseling? ☐ Yes ☐ No

Please describe your child's strengths, skills, and talents? _____

_____

_____

Describe any special areas of interest or hobbies (art, books, physical fitness, etc.): _____

_____

_____

Therapist Notes:

Family Counseling & Psychology Center, P.C.

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Legal Information

If the parents are separated or divorced, what is the current child custody/visitation arrangement? _____

_____

_____

☐ Yes ☐ No Is your child currently the subject of a custody case?

☐ Yes ☐ No Has your child been a ward of the court with DHS/DCFS guardianship?

☐ Yes ☐ No Does your child have any legal offenses on record or pending in the courts?

Therapist Notes: