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2485 Tech Drive, Bettendorf, IA. 52722 | Office: 563.355.1611 | Fax: 563.355.6617
303 18th Street, Rock Island, IL. 61201 | Office: 309.788.6374 | Fax:309.788.6375

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: _____________________

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: __________________

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 # ________________________

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? ____________________________

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 ________________________________

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	

Name: ______________________________ D.O.B.__________ ID #_______________

☐ Parents legally married or living together
☐ Parents temporarily separated
☐ Parents divorced or permanently separated

☐ Mother remarried Number of times ________
☐ Father remarried Number of times ________

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

☐ Emotional abuse
☐ Sexual abuse
☐ Physical abuse
☐ Parent substance abuse
☐ Teen pregnancy

☐ Neglect
☐ Violence in the home
☐ Crime victim
☐ Parent illness
☐ Placed a child for adoption

☐ Lived in a foster home
☐ Multiple family moves
☐ Homelessness
☐ Loss of a loved one
☐ 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			

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:

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_________

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	

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: ____

Name: ______________________________ D.O.B.__________ ID #_______________

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:

Name: ______________________________ D.O.B.__________ ID #_______________

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: