Child/Adolescent New Client Form

Client's Name: _____ Date: _____

Date of Birth: _____ Race: _____ Sex: _____

Parent/Guardian Completing Form: _____

Presenting Problems & Concerns:

Describe the problem(s) that brought you here today: _____

How old was your child when you first became aware of the problem? (Please describe history of problem, including date of onset) _____

Does your child believe that he or she has a problem? _____

☐ yes ☐ no Has your child ever received mental health treatment? Please list date of treatment, provider, and reason for treatment: _____

☐ yes ☐ no Has your child ever received psychological testing? Please provide copy of records and list date of testing and diagnosis: _____

Educational History:

Current Grade/Placement: _____ School: _____

This year's school grades: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Past school grades: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

This year's school behavior: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Past school behavior: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

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

☐ Attention Problems	☐ Incomplete Homework	☐ Learning Problems
☐ Poor grades	☐ Detentions/Suspensions	☐ Speech Problems
☐ School Avoidance	☐ Attendance Problems	☐ Teased/Picked on

☐ Yes ☐ No Has your child ever repeated or skipped a grade? _____

_____

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

_____

What do your child's teachers say about him/her? _____

_____

Learning Style:

☐ yes ☐ no Does your child keep notes of class lectures?

☐ yes ☐ no Does your child have a study place at home free from distractions?

☐ yes ☐ no Does your child seek help with his school work from teachers, parents, siblings, or peers, as needed?

☐ yes ☐ no Does your child review notes, read a textbook, and study before a test?

☐ yes ☐ no Does your child study material by reviewing it several times and rehearsing the answers?

☐ yes ☐ no Does your child receive rewards from parents for school performance?

Social History:

How does your child get along with other children? _____

Please explain any concerns about how your child interacts with others, including peers, teachers, and family members: _____

What are your child's general interests and hobbies? _____

What are your child's strengths? _____

What responsibilities does your child have at home, and how does he or she fulfill these responsibilities? _____

Family History:

Please list family members and ages:

☐ yes ☐ no Do any family members have a history of learning disabilities, ADHD, or other mental health or developmental disorder? If yes, please describe _____

☐ yes ☐ no Are there any factors in the family that might affect your child's ability to learn (e.g., limited economic resources; lack of privacy for studying; health problems; family problems)? If yes, please describe: _____

Medical Information:

Pediatrician or Primary Care Doctor: _____

Date of last physical exam: _____ Hearing/Vision Screening: _____

Does your child have any medical problems? Please list any CURRENT health concerns:

_____

_____

_____

Current Prescription Medications: ☐ None

Medication	Dosage	Date First Prescribed	Prescribed By

Current over-the-counter medications: _____

_____

_____

Legal Information:

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

_____

* Please provide a copy of pertinent custody documents

☐ yes ☐ no Is your child currently the subject of a custody case?

☐ yes ☐ no Has your child ever been a ward of the court with SCF/DCFS guardianship?

☐ yes ☐ no Does your child have any legal offences pending or on record?

_____ _____

Guardian Signature/Relation to Patient Printed Name Date