

Confidential Adolescent Information Form

Child Name:		
Child Age:		Date of Birth:
Child Ethnicity:	<input type="checkbox"/> African-American	<input type="checkbox"/> American/Alaskan Indian
	<input type="checkbox"/> Asian	<input type="checkbox"/> Latino/a
	<input type="checkbox"/> More than one race	<input type="checkbox"/> Native Hawaiian/Pacific Islander
		<input type="checkbox"/> Anglo <input type="checkbox"/> Other

Child Health History		
Primary Care Physician's Name:		
Date of Last Appt:		Phone:
Address:		
City:	State:	Zip:
Please list any serious illnesses or recent surgeries that are <i>current</i> for your child:		
Please list any serious illnesses, surgeries, and medical problems that your child has <i>ever</i> had:		

Please list any medications (prescribed and over-the-counter) that your child is <i>currently</i> taking:		
MEDICATION NAME	DOSAGE	FOR WHAT REASON?

<p>Does your child show physical signs of puberty? <input type="checkbox"/> Yes <input type="checkbox"/> No Dates:</p> <p>If yes, at what age did these signs occur?</p> <p>Please describe:</p>

Child Psychological History	
Has your child ever seen a therapist or Psychiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dates:	
If yes, for what concerns, and what was helpful or not helpful about this treatment?	
Has your child ever been involved in illegal behavior? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, for what reason?	

Child School Information	
Name of school that your child is attending:	
Grade Level:	Estimated GPA:
Has your child ever been given an IEP (Independent Educational Plan) or any other type of Special learning service? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please explain:	
Has your child ever had disciplinary action at school or have concerns been express by teachers? <input type="checkbox"/> Yes <input type="checkbox"/> No Dates:	
If yes, please explain:	

Child Social Information

Is your child involved in extracurricular activities? Yes No
If yes, what type and how often?

Is your child involved in athletics? Yes No
If yes, please describe:

Does your child have a job? Yes No
If yes, please describe:

Does your child have a driver license or permit? Yes No

Briefly explain why your child is seeking therapy at this time:

List any major changes or life events that have occurred for your child in the last two years:

Is there any additional information that would be important to know about your child:

Legal Guardian Name (Please print):			
Date:			
Legal Guardian Age:		Legal Guardian Date of Birth:	
Driver's License #:			
Parental Status: Description of relationship to the child:			
<input type="checkbox"/> Biological Parent	<input type="checkbox"/> Step-parent/co-parent	<input type="checkbox"/> Legal Guardian	
<input type="checkbox"/> Foster Parent	<input type="checkbox"/> Adoptive Parent	<input type="checkbox"/> Other:	
Home Address:			
City:	State:	Zip:	
Home Phone:		Cell Phone:	
Email:			
Employment Status:			
<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/> Unemployed			
Employer Name:			Job Title:
Spouse/Partner Employer Name:			Job Title:
Active Military: <input type="checkbox"/> Yes <input type="checkbox"/> No	Branch:	Date Entered:	
Rank:			
Time served overseas: <input type="checkbox"/> Yes <input type="checkbox"/> No		Time served in combat: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ethnicity:	<input type="checkbox"/> African-American	<input type="checkbox"/> American/Alaskan Indian	<input type="checkbox"/> Anglo
	<input type="checkbox"/> Asian	<input type="checkbox"/> Latino/a	<input type="checkbox"/> Other
	<input type="checkbox"/> More than one race	<input type="checkbox"/> Native Hawaiian/Pacific Islander	
Affectional/Sexual Orientation: <input type="checkbox"/> Heterosexual <input type="checkbox"/> Lesbian/Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Uncertain			
Religion:			
<input type="checkbox"/> Catholic	<input type="checkbox"/> Protestant	<input type="checkbox"/> Jewish	<input type="checkbox"/> Islamic
<input type="checkbox"/> Buddhist	<input type="checkbox"/> Hindu	<input type="checkbox"/> Christian	<input type="checkbox"/> Other:
Highest Level of Education Completed:			
<input type="checkbox"/> Some High School	<input type="checkbox"/> High School/GED		
<input type="checkbox"/> Some College	<input type="checkbox"/> Technical/Apprentice cert.		
<input type="checkbox"/> AA Degree	<input type="checkbox"/> BA/BS Degree		
<input type="checkbox"/> MA/MS Degree	<input type="checkbox"/> Md/JD/Doctoral Degree		

Please fill in the chart below regarding your <u>current living situation</u> (who lives in your home)				
FIRST NAME	AGE	ETHNICITY	OCCUPATION	RELATIONSHIP

Emergency Contact: Please identify an individual that we may contact in the event of an emergency.			
Name:		Relationship to you:	
Address:			
City:	State:	Zip:	
Home Phone:		Cell Phone:	

Person to be billed for fees:			
Name:		Relationship to you:	
Address:			
City:	State:	Zip:	
Home Phone:		Cell Phone:	
How did you hear about <i>Therapy Changes</i> ?			

Thank you for your time, and I look forward to meeting you soon!