Pathways to Change, LLC
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Child/Adolescent Information Form

Date:

Name of Child/Adolescent:	Age:	Date of Birth:
Address:		Phone:
Child/Adolescent lives with; Both Parents ☐ Mother ☐ Father ☐ Other		
Person Completing This Form:		Relationship to Client:

Family and Relationship Information

Mother's Name:	Age:	Occupation:
Address:		
Home Phone:	Cell Phone:	Work Phone:

Father's Name:	Age:	Occupation:
Address:		
Home Phone:	Cell Phone:	Work Phone:

Other Household Members and Siblings:

Name	Relationship	Age	Address

Please describe your current concerns:

The reason that I decided to bring my son or daughter for counseling is:

Are there any stressors or circumstances that may be affecting your child?

Are there other things that may be causing the problems?

Please read through the following list and check any concerns that apply to your child and identify with "P" for past concern, "N" for never a concern, * for present, and ** for present qualities of major concern.

☐ Depression	☐ Sleep problems	☐ Poor anger control	☐ Distractibility
☐ Low self esteem	☐ Nightmares	☐ Oppositional to requests	☐ Hyperactivity
☐ Concentration problems	☐ Running away	☐ Disobeys most rules at home	☐ Impulsivity
☐ Fatigue/low energy	☐ Eating concerns	☐ Withdrawal from others	☐ Disorganized
☐ Anxiety	☐ Over or under eating	☐ Obsessive thinking	☐ Physical aggression
☐ Worry/fears	☐ Binging and Purging	☐ Alcohol/substance use	☐ Stealing
☐ Panic attacks	☐ Poor body image	☐ Difficulty following direction	☐ Lying

Abuse History

Has your child/adolescent experienced emotional, physical, or sexual abuse, please explain:

Safety Concerns

Does your child have or has he/she ever had suicidal or self-injurious thoughts or impulses? Yes☐ No☐

Has she/he ever made a suicide attempt or engaged in self-injurious behaviors? Yes ☐ No☐

Has your child had thoughts of or engaged in harming others or property? Yes☐ No☐

Please describe any "yes" answers._____

_____

Education

Name of School_____ Grade____ Name of school contact person _____

Has your child been involved in any special education program? _____

Has your child had problems with School Attendance? _____ Change in grades? _____ Other difficulties?_____

_____

Medical Information

Primary Care Physician_____ Clinic_____

Please describe any medical conditions that your child has now or has had in the past, including headaches or stomach aches.

_____

_____

Please list any medications that your child takes, including dosages, and who prescribes the medication. _____

_____

Mental Health and Substance Abuse History

Has your child received mental health or substance abuse treatment? If so, please write down the location, provider and dates attended and treatment focus.

_____

_____

_____

_____

_____

Are you aware if your child/adolescent uses alcohol, marijuana, other chemicals, or tobacco and if so, how much and how often? Have you or other people been concerned about his/her use or possible use?

_____

_____

_____

_____

_____

Have any family members (parents, grandparents, siblings, aunts, uncles etc) been diagnosed as having a chemical dependency condition, or have people expressed concern about their use? Have any members received therapy for mental health or substance abuse? _____

Strengths and Positive Qualities

Please describe your child's strength and talents and the ways that you see him/her doing positive things for her/himself.

_____

_____

Please describe what you and others have done to try to help your child/adolescent with his/her concerns. Please add any qualities that you and other family members have that contribute to positives for your child/adolescent.

_____

Other Information that you would like to add: