

The Center for Personal Growth
4656 30th St., San Diego, Ca. 92116
Telephone: (619) 405-6378
Fax: (619)528-8054

Client Information (Child/Adolescent)

To be completed by the child/adolescent's parent(s)

*****Please Note: If additional space is needed to answer the following questions, please use the back of this form.*****

General Information:

Child/Adolescents Name: _____

Child/Adolescents Address: _____

Child/Adolescents Telephone Number: _____

Name of Child/Adolescents School and Grade: _____

Child/Adolescents Social Security Number: _____

Child/Adolescents Date of Birth: _____

Biological Parents Name and address:

Mother: _____

Father: _____

Step-Parents Name (if applicable):

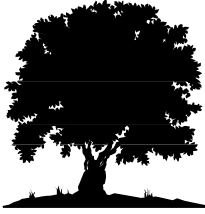
Step-Mother: _____

Step-Father: _____

Custody Arrangements:

Who has legal custody of the child/adolescent? _____

Who has physical custody of the child/adolescent? _____



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Referral Source:

How did you hear about the Center for Personal Growth?

Insurance information:

What is the name of your insurance company, contact name and telephone number information, and policy/claim/case number?

Psychiatric History:

Has your child/adolescent ever been in therapy before? (Name and telephone # of therapist; dates seen):

Medical History:

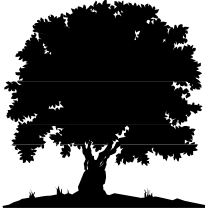
Does the child/adolescent have any current medical problems? (Include recent illness, injury or surgery, any allergies to medications and name/# of MD):

Is the child/adolescent currently taking any medications? (Include over the counter medications):

Substance Abuse:

Does the child/adolescent have any current alcohol and/or illicit drug use? (Include type of drink, # of drinks and frequency, include type of drug and frequency):

Has the child/adolescent ever received treatment for any type of substance abuse? (Include 12 step, inpatient treatment and outpatient therapy):



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Presenting Problem:

For what reasons are you seeking counseling today?

What changes would you like to see take place in your child/adolescents life?

Please describe the child/adolescents current symptoms (Include emotional, physical, cognitive and relationship concerns):

Risk Assessment: (Please answer all questions based on your child/adolescents **current** mental state or circumstances):

Suicidal Thoughts Yes No Homicidal Thoughts Yes No
 Domestic Violence Yes No Physical/Sexual/Verbal Abuse Yes No
 Mania Yes No Psychosis Yes No Paranoia Yes No

If Yes, Please explain with dates for each incident:

Any history of above or attempts of the above? Yes No

Family psychiatric history:

Please include history of symptoms or treatment for immediate and extended family if known.

Thank you for completing this questionnaire. All information will be used to help you and your therapist complete a thorough assessment and develop a treatment plan. By signing below you acknowledge that you understand all the questions asked on this form and that you have answered all questions honestly and accurately.

Parents Signature: _____ Date: _____