

# Samaritan Counseling Services

## Child and Adolescent Personal and Medical Information Form

ID #: \_\_\_\_\_ Initials: \_\_\_\_\_

**DIRECTIONS:**

*Please fill out this form as completely as you can. Some of the questions may seem overly personal, but your frank answers will let us help in the best way we can as many of these factors play an important role in causing psychological problems. You may wish to consult your doctor to help you answer the questions fully.*

**A. CLIENT'S IDENTIFYING INFORMATION:**

**1. Child/Adolescent's Information:**

Name: \_\_\_\_\_ Ethnicity/Race: \_\_\_\_\_

Address: \_\_\_\_\_ DOB: \_\_\_\_\_

Briefly state reasons for seeking treatment at this time? \_\_\_\_\_

\_\_\_\_\_

Chief Complaint: \_\_\_\_\_

\_\_\_\_\_

Who referred you to Samaritan? \_\_\_\_\_

Why did you choose Samaritan? \_\_\_\_\_

**2. Caretaker's Information:**

Primary: \_\_\_\_\_ Additional: \_\_\_\_\_

Address (if different from client): \_\_\_\_\_

Phone #s: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Indicate work status/place of employment for Primary caretaker \_\_\_\_\_

Indicate work status/place of employment for Additional caretaker \_\_\_\_\_

(Work Status as follows: Disabled, Ft caretaker, Ft permanent job, Pt job, Underemployed, Unemployed)

Family Denomination/Group: \_\_\_\_\_ Pastor/Leader: \_\_\_\_\_

Did a religious leader make any referral? \_\_\_\_\_ If yes, do you wish to sign a release? \_\_\_\_\_

**3. Family/Household Constellation:**

Name	Age	Deceased	Ethnicity Race	Occupation School/Grade	Live with Client, yes/no If not, indicate address	Visitation Arrangement
Birth Mother						
Birth Father						
Siblings:						
Other members:						

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**B. CULTURE, ETHNIC, AND RELIGIOUS INFO:**

Does your family identify with a particular cultural, ethnic and/or religious group? (If yes, explain) \_\_\_\_\_.  
Of what overall importance is this in your family's life? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**For therapist use only:**

**Family Hx/Present Family Situation/Family's Expectations of Child & Hx of Presenting Problem:**

**C. PERINATAL HISTORY:**

**1. Prenatal:**

	<u>No</u>	<u>Yes</u>	<u>Week of Pregnancy</u>	<u>Comment</u>
Mother's pregnancy entailed:	_____	_____	_____	_____
Accidents:	_____	_____	_____	_____
Alcohol:	_____	_____	_____	_____
Cigarettes:	_____	_____	_____	_____
Cocaine:	_____	_____	_____	_____
Environmental (emotional/physical)	_____	_____	_____	_____
Marijuana:	_____	_____	_____	_____
Maternal illnesses:	_____	_____	_____	_____
Other pregnancy complications:	_____	_____	_____	_____
Over the counter medications:	_____	_____	_____	_____
Prescription medications:	_____	_____	_____	_____
Other:	_____	_____	_____	_____
Any in utero complication/diagnosis	_____	_____	_____	_____

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### 2. Birth:

Labor/delivery details:

_____ At term (38-42 weeks)	_____ Normal Birth weight	_____ lbs	_____ oz
_____ Pre-term _____ weeks	_____ Low (<5 lbs, 8 oz)	_____ lbs	_____ oz
_____ Post-term _____ weeks	_____ High (> 8 lbs, 13 oz)	_____ lbs	_____ oz

Any labor complications:    \_\_\_ No    \_\_\_ Yes \_\_\_\_\_

### 3. Postnatal:

Was child hospitalized after birth? If so, why? \_\_\_\_\_

Was Post partum depression or psychosis present? \_\_\_\_\_

## D. DEVELOPMENTAL MILESTONES:

### 1. Infancy/Toddler:

Rolling over (average 4 to 7 months)	_____ Normal	_____ Delayed, age _____
Sitting alone (average 7 to 10 months)	_____ Normal	_____ Delayed, age _____
Walking alone (average 10-18 months)	_____ Normal	_____ Delayed, age _____
Saying first word (average 12-18 months)	_____ Normal	_____ Delayed, age _____
Say simple sentences (average 24 months)	_____ Normal	_____ Delayed, age _____
Toilet trained (average 3 years)	_____ Normal	_____ Delayed, age _____

Were there any illnesses in the first few months of life? \_\_\_\_\_

Were there any difficulties in infancy with (please circle):

*Feeding      Sleeping      Unwarranted crying      Weaning from breast/bottle      Weight Gain*

Please explain: \_\_\_\_\_

Describe and give age of any significant medical illnesses, including chronic ear infections, high fevers, operations, or accidental injuries:

Describe and give age of any significant psychological concerns, including sleeping difficulties, head banging, excessive thumb sucking, excessive temper tantrums, failure to thrive/early depression:

### 2. Puberty:

M/Age puberty began (____)	_____ Normal	If not, explain _____
F/Age of menstruation (____)	_____ Normal	If not, explain _____
Reaction to changes	_____ Normal	If not, explain _____

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**For therapist's use only:**  
**Developmental History** \_\_\_\_\_ **(Within Normal Limits?)** \_\_\_\_\_ **If "No", please explain** \_\_\_\_\_

**Motor development & functioning:** \_\_\_\_\_

**Speech, hearing & language functioning:** \_\_\_\_\_

**Visual functioning:** \_\_\_\_\_

**Any other concern:** \_\_\_\_\_

**E. SCHOOL STATUS**

**School:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Teacher's name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Special Education:** (please circle below)

Learning Disability    Emotionally Impaired    Attention Deficit Disorder    Speech and Language  
501/Support Services (ex. Homework support/special tutoring, etc.)

Please give specifics: \_\_\_\_\_

**Any special testing in school?** \_\_\_\_\_

**Any special testing for other reason?** \_\_\_\_\_

**F. CHILD'S SCHOOL AND SOCIAL HISTORY**

**1. Age the child started school/preschool:** \_\_\_\_\_ **years old.**

Child able to form attachment to significant other, caretaker, school staff? Yes, No Who? \_\_\_\_\_

Child's temperament was? \_\_\_\_\_

**2. Child's Strengths and Interests:**

Activities your child pursues: \_\_\_\_\_

Activities you would like child to pursue: \_\_\_\_\_

Activities child has expressed interest in: \_\_\_\_\_

Child seems better than others at: \_\_\_\_\_

Child seems behind others at: \_\_\_\_\_

How satisfied is your child with how s/he spends their leisure time? (circle one):

1) very dissatisfied    2) < satisfied    3) satisfied    4) > satisfied    5) very satisfied

Is amount of child's leisure time: 1) < adequate    2) adequate    3) > adequate    4) much too much

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**3. Daily Social Activities (check only if present and give best average estimate)**

Afterschool activities	# times a week _____	# hrs a day _____
Computer time (games and internet)	# times a week _____	# hrs a day _____
Discretionary time	# times a week _____	# hrs a day _____
Homework (at home, not in school programs)	# times a week _____	# hrs a day _____
Play/spend time with friends, siblings	# times a week _____	# hrs a day _____
Time with parents (ex. meals, talking, going places)	# times a week _____	# hrs a day _____
Sports (favorite sports _____)	# times a week _____	# hrs a day _____
Watching TV (favorite shows _____)	# times a week _____	# hrs a day _____

**4. Areas of Concern:**

	Preschool (date _____)		Elementary (K-5)		Middle (6-8)		High School (9-12)	
	<u>No</u>	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>	<u>Yes</u>
	Anxiety, fears:	_____	_____	_____	_____	_____	_____	_____
Being bullied:	_____	_____	_____	_____	_____	_____	_____	_____
Bullying:	_____	_____	_____	_____	_____	_____	_____	_____
Change in school performance								
Homework difficulties:								
Hyperactive behaviors:	_____	_____	_____	_____	_____	_____	_____	_____
Learning in specific subjects:	_____	_____	_____	_____	_____	_____	_____	_____
Noncompliance:	_____	_____	_____	_____	_____	_____	_____	_____
Not paying attention:	_____	_____	_____	_____	_____	_____	_____	_____
Physical aggression:	_____	_____	_____	_____	_____	_____	_____	_____
Peer relationship:	_____	_____	_____	_____	_____	_____	_____	_____
Problems following instructions:								
Repeated grades:	_____	_____	_____	_____	_____	_____	_____	_____
Separating from parents:	_____	_____	_____	_____	_____	_____	_____	_____
Social problems:	_____	_____	_____	_____	_____	_____	_____	_____
Sudden grade changes:	_____	_____	_____	_____	_____	_____	_____	_____
Temper tantrums:	_____	_____	_____	_____	_____	_____	_____	_____
Other difficulties:	_____	_____	_____	_____	_____	_____	_____	_____

**For therapist's use only:**

**School History and Current School Performance & Leisure Time/Daily Activities Pattern:**

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### **G. BEHAVIORS**

**Past**    **Current** (Please comment on frequency and duration.)

Aggression:	_____	_____	_____
Bedwetting	_____	_____	_____
Bowel control difficulty:	_____	_____	_____
Clingy:	_____	_____	_____
Daydreaming:	_____	_____	_____
Defiance:	_____	_____	_____
Eating disturbances: (type?)	_____	_____	_____
Excessive fears:	_____	_____	_____
Excessive masturbating:	_____	_____	_____
Family conflict	_____	_____	_____
Fear of being alone:	_____	_____	_____
Fear of certain people:	_____	_____	_____
Fighting:	_____	_____	_____
Hurts self:	_____	_____	_____
Loss of appetite:	_____	_____	_____
Lying:	_____	_____	_____
Mood swings:	_____	_____	_____
Outbursts:	_____	_____	_____
Over compliance:	_____	_____	_____
Poor concentration:	_____	_____	_____
Self harm actions:	_____	_____	_____
Self harm ideas:	_____	_____	_____
Sexual acting out:	_____	_____	_____
Sexual behavior:	_____	_____	_____
Stares:	_____	_____	_____
Tantrums:	_____	_____	_____
Early morning waking:	_____	_____	_____
Nightmares:	_____	_____	_____
Trouble falling asleep:	_____	_____	_____
Trouble staying asleep:	_____	_____	_____
Weight gain/loss:	_____	_____	_____
Withdrawn:	_____	_____	_____
Other:	_____	_____	_____

### **H. LEGAL PROBLEMS:**

Does the family have any pending legal problems? \_\_\_\_\_.

Have you had prior legal problems in any way associated with your seeking treatment for your child at this time? (if yes to either question above, please elaborate.) \_\_\_\_\_.

\_\_\_\_\_.

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### **I. LOSSES & TRAUMAS**

	<b><u>Date</u></b>	<b><u>Age of Child</u></b>	<b><u>Child's Emotional Reaction</u></b>
Accidents:	_____	_____	_____
Change of caretaker:	_____	_____	_____
Change of home/move:	_____	_____	_____
Change of school:	_____	_____	_____
Death (who?):	_____	_____	_____
Family alcohol/drug use:	_____	_____	_____
Legal Problems (ex. jail) (who?):	_____	_____	_____
Marital separation/divorce:	_____	_____	_____
Medical:	_____	_____	_____
Neglect:	_____	_____	_____
Emotional abuse:	_____	_____	_____
Physical abuse:	_____	_____	_____
Sexual abuse:	_____	_____	_____
Other loss or trauma (what?):	_____	_____	_____

### **J. PREVIOUS THERAPY, COUNSELING, OR PSYCHIATRIC HOSPITALIZATIONS**

\_\_\_\_\_ **No:** You need not answer the following.

\_\_\_\_\_ **Yes:** Please list first any psychiatric hospitalizations, then the most recent therapy or counseling.

1. Dates \_\_\_\_\_ through \_\_\_\_\_

Agency Name: \_\_\_\_\_

Therapist Name/Degree: \_\_\_\_\_

Address: \_\_\_\_\_

Type of treatment: \_\_\_\_\_

Outcome? \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_

(intern, MA, MD, MSW, PhD)

City: \_\_\_\_\_ State: \_\_\_\_\_

Frequency: \_\_\_\_\_

2. Dates \_\_\_\_\_ through \_\_\_\_\_

Agency Name: \_\_\_\_\_

Therapist Name/Degree: \_\_\_\_\_

Address: \_\_\_\_\_

Type of treatment: \_\_\_\_\_

Outcome? \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_

(intern, MA, MD, MSW, PhD)

City: \_\_\_\_\_ State: \_\_\_\_\_

Frequency: \_\_\_\_\_

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**K. CLIENT AND FAMILY HEALTH HISTORY**

Please indicate if client or any other family member had in the past or currently has any of the following:

Any unanswered questions will be considered a “no” response.

(If adopted, please check here \_\_\_\_\_ and complete form for adoptive family.)

	Client in past (when)	Client at present	Significant Other (when)
Anemia	_____	_____	_____
Arthritis/rheumatism	_____	_____	_____
Cancer or tumor	_____	_____	_____
Gall Bladder	_____	_____	_____
Glaucoma	_____	_____	_____
Liver Disease	_____	_____	_____
Pancreatitis	_____	_____	_____
 <b><u>Cardiovascular:</u></b>			
Heart trouble	_____	_____	_____
High blood pressure	_____	_____	_____
Stroke	_____	_____	_____
 <b><u>Ear, Nose and Throat:</u></b>			
Asthma	_____	_____	_____
Breathing problems	_____	_____	_____
Ear infections	_____	_____	_____
Emphysema	_____	_____	_____
Tuberculosis	_____	_____	_____
 <b><u>Gastro-intestinal:</u></b>			
Bowel control trouble	_____	_____	_____
Constipation trouble	_____	_____	_____
Excessive stomach aches	_____	_____	_____
Loss of appetite	_____	_____	_____
Marked weight loss	_____	_____	_____
Marked weight gain	_____	_____	_____
Persistent diarrhea	_____	_____	_____
Persistent nausea/vomiting	_____	_____	_____
Stomach trouble/ulcers	_____	_____	_____
 <b><u>Glandular:</u></b>			
Diabetes	_____	_____	_____
Hepatitis	_____	_____	_____
Hypoglycemia	_____	_____	_____
Thyroid problem	_____	_____	_____
Other hormone problems	_____	_____	_____

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<b><u>Mental Health:</u></b>	<b>Client in past (when)</b>	<b>Client at present</b>	<b>Family member(who/when)</b>
Angry/out of control	_____	_____	_____
Anorexia	_____	_____	_____
Bulimia	_____	_____	_____
Compulsive Eating	_____	_____	_____
Emotional abuse	_____	_____	_____
Manic-depressive disease	_____	_____	_____
Panic/anxiety	_____	_____	_____
Physical abuse	_____	_____	_____
Psychotic episode	_____	_____	_____
Schizophrenia	_____	_____	_____
Sexual abuse	_____	_____	_____
Suicidal thoughts	_____	_____	_____
Suicide attempt	_____	_____	_____
<b><u>Neurological:</u></b>			
Blurred vision	_____	_____	_____
Dizziness	_____	_____	_____
Epilepsy	_____	_____	_____
Frequent headaches	_____	_____	_____
Head injury	_____	_____	_____
Headaches	_____	_____	_____
Meningitis/encephalitis	_____	_____	_____
Passing out	_____	_____	_____
Seizures	_____	_____	_____
Sleeping difficulties	_____	_____	_____
<b><u>Substance Abuse:</u></b>			
Alcohol abuse	_____	_____	_____
Substance abuse	_____	_____	_____
<b><u>Special Senses:</u></b>			
Visual or eye problems	_____	_____	_____
Hearing loss	_____	_____	_____
Severe ear infections	_____	_____	_____
<b><u>Urological/Gynecological:</u></b>			
Bladder infections	_____	_____	_____
Blood in urine	_____	_____	_____
Pain/burning urination	_____	_____	_____
Soreness in genital areas	_____	_____	_____
Yeast infections	_____	_____	_____
Urinary frequency	_____	_____	_____

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### L. CLIENT MEDICAL HISTORY:

Name of Physician: \_\_\_\_\_ Date of last exam: \_\_\_\_\_

City and State: \_\_\_\_\_ Phone #: \_\_\_\_\_

Findings (e.g., test results) \_\_\_\_\_

Past hospitalizations: \_\_\_\_\_

How would you rate your child's physical health?    Excellent    Good    Fair    Poor    Very Poor

Child's current weight? \_\_\_\_\_ lbs.;    Child's current height? \_\_\_\_\_ ft. \_\_\_\_\_ in.

Does child have any allergies?    \_\_\_\_\_ **No**    \_\_\_\_\_ **Yes** Please indicate type (food/medication/other).

If yes, indicate Type \_\_\_\_\_ Reaction \_\_\_\_\_.

Type \_\_\_\_\_ Reaction \_\_\_\_\_.

Type \_\_\_\_\_ Reaction \_\_\_\_\_.

Please list all current medications, doses, frequency, and length of time your child has been taking them:

Name of Drug                      Dose                      Frequency                      How Long Taken

<u>Name of Drug</u>	<u>Dose</u>	<u>Frequency</u>	<u>How Long Taken</u>

Please indicate whether or not your child uses the following non-medical drugs. If yes, indicate usage.

	<u>No</u>	<u>Yes</u>	<u>How Much</u>	<u>How Long</u>
Alcohol	_____	_____	_____	_____
Aspirin	_____	_____	_____	_____
Cigarettes	_____	_____	_____	_____
Coffee/Tea	_____	_____	_____	_____
Cola	_____	_____	_____	_____
Cold remedies	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____
Sleeping Pills	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Other (_____)	_____	_____	_____	_____

I have read the Treatment and Policy Information Sheet and have filled out this form completely and accurately. I understand that the information I have given on this form will be part of my permanent record and will be treated confidentially, as is covered in the Treatment and Policy Information Sheet under "Confidentiality."

**Patient's (or Guardian's) Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Samaritan Counseling Services**  
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**For therapist's use only:**  
**Interpretive Diagnostic Summary:**

**For official use only:** \_\_\_\_\_  
**Physical Health and Nutritional Concerns:**

Psychiatrist: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Referral: \_\_\_ Yes    \_\_\_ No    Comments: \_\_\_\_\_