TAMPA COUNSELING AND WELLNESS

CHILD/TEEN INFORMATION FORM

Child's Name: _____ Todays Date: _____/_____/_____

Birth Date: _____/_____/_____ Age: _____ Gender: _____

Sexual Orientation: _____ Relationship Status: _____

Race: _____ Ethnicity: _____

Religion: _____ Languages: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____-_____ Voice Message OK: ☐Yes ☐No Text Message OK: ☐Yes ☐No

E-mail: _____

Parent/Legal Guardian Name (1): _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____-_____ Voice Message OK: ☐Yes ☐No Text Message OK: ☐Yes ☐No

E-mail: _____

Parent/Legal Guardian Name (2): _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____-_____ Voice Message OK: ☐Yes ☐No Text Message OK: ☐Yes ☐No

E-mail: _____

Would you like to receive appointment reminders via email? ☐Yes ☐No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

CURRENT ISSUE:

Reason for seeking services:

_____
_____

When did the issue(s) and/or symptoms begin? _____

What caused/contributed to the issue(s) and/or symptoms?

_____
_____

With whom does the child primarily reside?

_____
_____

List all individuals that currently live with the child:

Name	Age	Relationship

Has the child ever experienced any trauma(s) or stressful event(s)? ☐No ☐Yes

If yes, please describe: _____

How does the child cope with stress? _____

Has the child ever received *mental health* services in the past? ☐No ☐Yes

If yes, please provide:

Name of provider or facility: _____

Location (city/state): _____

Length of treatment: _____

Reason for treatment: _____

Diagnosis: _____

Has a *family member* ever received mental health treatment? ☐No ☐Yes

If yes, please describe: _____

MEDICAL/HEALTH HISTORY

Name of child's primary care physician/doctor: _____

Address: _____ Phone: _____

Please list any ***medical*** problems child is currently experiencing or has been diagnosed with in the past:

_____

_____

Please list medication child currently takes:

Medication	Dosage	Condition/Reason

Please describe child's past or current **alcohol/drug** use:

_____

_____

Please describe child's past/current **legal issues**:

_____

_____

Has the child ever experienced any sexual, physical, or psychological abuse? ☐ No Yes If yes, briefly explain:

_____

_____

ACADEMIC INFORMATION

School Name: _____ Grade: _____

Has the child skipped or repeated any grades: ☐ No ☐ Yes Explain: _____

Has child received any special education or gifted services: ☐ ☐ No ☐ Yes Explain: _____

EMPLOYMENT HISTORY (if applicable)

Current Occupation: _____ Title: _____

Employer: _____ How Long: _____

DEVELOPMENTAL HISTORY

Did the child experience any of the following? ☐ Premature pregnancy ☐ Slow to Walk ☐ Slow to talk

☐ Low birth weight ☐ Trouble toilet training ☐ Bedwetting

Has child ever received any of the following?

Speech Therapy? ☐ Yes ☐ No Occupational Therapy? ☐ Yes ☐ No Physical Therapy? ☐ Yes ☐ No

PARENT/GAURDIAN MARITAL HISTORY

Parent (1) marital status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Number of marriages: _____

Number of years: Married ____ Separated ____ Divorced ____ Widowed _____

Number of children: _____

Who resides in your home with you? _____

Parent (2) marital status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Number of marriages: _____

Number of years: Married ____ Separated ____ Divorced ____ Widowed _____

Number of children: _____

Who resides in your home with you? _____

If parents divorced, how old was the child when they divorced? _____

How did child feel about the separation and/or divorce? _____

Which parent did child primarily reside with? _____

Did child maintain contact with your nonresidential parent? ☐ Yes ☐ No

What are some of the child's strengths? _____

What are some of the child's limitations? _____

_____ _____

Parent/Legal Guardian Signature **Printed Name**

_____

Date