

PERSONAL DATA FORM – CHILD

Person Filing this out: _____ **Today's date:** _____

Client Name: _____

Date of Birth _____ Age _____

Gender (circle): M F

School: _____ Grade: _____ Special Ed: _____

Contact Person: _____ Number: _____

Parent(s)/Primary caregiver(s)/Guardian:

Father's Name: _____ Age _____

Occupation _____

Mother's Name: _____ Age _____

Occupation _____

Mailing address:

Street _____ City/State _____ Zip code _____

Telephone #'s: Home _____ Work _____ Cell _____

Emergency Contact:

Name: _____ Relationship: _____ Number: _____

May I call you and leave a message on your home phone? No Yes At work? No Yes

How did you hear about me? I would like to contact this person to thank them for the referral. If this is ok, please list their name and sign your name below.

Referred by:

Your Signature: _____

Present Problem

Why are you seeking psychotherapy for your child? Goals?

Please check any of the following that currently apply to your child:

- | | |
|---|--|
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Poor school performance |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Eating problems |
| <input type="checkbox"/> Lies | <input type="checkbox"/> Lonely |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Worthless feelings |
| <input type="checkbox"/> Homicidal ideation | <input type="checkbox"/> Indecisive |
| <input type="checkbox"/> Truancy | <input type="checkbox"/> Hyperactive |
| <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Poor attention |
| <input type="checkbox"/> Perseverates | <input type="checkbox"/> Auditory Hallucinations |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Racing thoughts |
| <input type="checkbox"/> Unable to make friends | <input type="checkbox"/> Forgets easily |
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Anxious |
| <input type="checkbox"/> Excessive guilt | <input type="checkbox"/> Drug use |
| <input type="checkbox"/> Sex Abuse | <input type="checkbox"/> Visual Hallucinations |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Negative body image | <input type="checkbox"/> Isolates |
| <input type="checkbox"/> Self-injury (i.e. cutting) | <input type="checkbox"/> Running away |
| <input type="checkbox"/> Fire setting | <input type="checkbox"/> Harming animals |

Psychotherapy History

Please list any previous mental health services including hospitalizations in the space below:

Therapist/Doctor Dates Reason for treatment

1. _____
2. _____

Has your child ever made a suicide attempt? If yes, please describe circumstances, how and when.

Has anyone in your family had psychological or psychiatric problems? If yes, please describe.

Has anyone in your family had alcohol or drug problems? If yes, please describe.

For teens:

Pregnant now? No Unsure Yes (Due date: _____)

Abortions? No Yes

Is your child being seen by a psychiatrist? No Yes

If so, name of doctor: _____ Number: _____

Please list all medications your child currently uses:

Name of Medication Dosage Prescribed by

Alcohol/Drug History: (place N/A if not applicable)

Is your child in treatment for alcohol or drug use _____

Please check which of the following substances you have used:

| <u>Substance</u> | <u>Ever used?</u> | <u>Used in the past year?</u> | <u>Frequency?</u> | <u>Comments</u> |
|--------------------------------------|-------------------|-------------------------------|-------------------|-----------------|
| Caffeine | | | | |
| Tobacco | | | | |
| Inhalants/Glue | | | | |
| Marijuana/Hashish | | | | |
| Stimulants/Amphetamines (speed) | | | | |
| Sedatives/Barbiturates | | | | |
| Xanax/Valium/Librium (tranquilizers) | | | | |
| LSD/Psychedelics/PCP (angel dust) | | | | |
| Cocaine/Crack | | | | |
| Heroin/Opiates | | | | |
| Ecstasy | | | | |

The Following questions are to be filled out by your child.

Use 3 words that describe how you see yourself.

Favorite game and/or activities? _____

Favorite foods? _____

Favorite color(s)? _____

Do you have a pet? If so, what is his/her name? _____

Why are you here today?

What would you like me to help you with? _____

Who are the supportive people in your life?

Parent(s) Religious/spiritual community
 Friend(s) Other supportive relationship(s)
 Sibling(s) Relative(s)
 Professional caregiver Pet(s)

Please check off your personal strengths.

Likable Confident
 Appearance Creative
 Hopeful Sensitive
 Emotionally stable Intelligent
 Healthy Witty
 Adaptable Persistent
 Tolerant Loving
 Resourceful Other _____

What do you like best about yourself?
