THE COMMUNITY COUNSELING CENTER OF MOORESTOWN VNA

PEDIATRIC CLIENT INFORMATION FORM

Name of Child:_____ Date:_____

Address:_____ Gender: Male ☐ Female ☐

City:_____ State:_____ Zip:_____ Date of Birth:_____

Social Security Number:_____

Contact Telephone Numbers

Please complete relevant information and indicate the number at which you wish to be contacted first.

	OK to leave Messages? Yes	No	Primary Contact number?
Home: ( )_____	☐	☐	☐
Work: ( )_____	☐	☐	☐
Cell : ( )_____	☐	☐	☐

Parent's email address:_____

Emergency Contact Information

Name:_____ Relationship to Child:_____

Home: ( )_____

Work: ( )_____

Cell : ( )_____

Primary Care Physician

Primary Care Physician:_____

Physician's Address:_____

Physician's Phone #:_____ Physician's Fax #:_____

By who were you referred? _____

Therapist notes:
Init:

PEDIATRIC CLIENT INFORMATION FORM

Name:_____ Date:_____

REPRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought your child here today:_____

_____

Please check all the behaviors and symptoms that you consider problematic:

☐ Distractibility	☐ Fear Away from Home	☐ Suspicion/Paranoia
☐ Hyperactivity	☐ Social Discomfort	☐ Racing Thoughts
☐ Impulsivity	☐ Obsessive Thoughts	☐ Excessive Energy
☐ Boredom	☐ Excessive Behavior	☐ Wide Mood Swings
☐ Poor Memory	☐ Aggression/Fights	☐ Sleep Problems
☐ Confusion	☐ Loneliness	☐ Nightmares
☐ Seasonal Mood Changes	☐ Low Self Worth	☐ Eating Problems
☐ Sadness/Depression	☐ Guilt/Shame	☐ Gambling Problems
☐ Loss of Pleasure/Interest	☐ Fatigue	☐ Computer Addiction
☐ Thoughts of Death	☐ Change in Appetite	☐ Pornography Issues
☐ Hopelessness	☐ Lack of Motivation	☐ Relationship Issues
☐ Crying Spells	☐ Withdrawal from People	☐ Sexual Problems
☐ Self Harm Behaviors	☐ Anxiety/Worry	☐ School/Work Issues
☐ Other	☐ Panic Attacks	☐ Alcohol/Drug Use

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Are your child's issues affecting any of the following?

☐ Performing Everyday Tasks ☐ Self -Esteem ☐ Relationships ☐ Hygiene

☐ School/Work ☐ Housing ☐ Legal matters

☐ Recreational Activities ☐ Sexual Activity ☐ Health

☐ Yes ☐ No Has your child ever had thoughts, made statements, or attempted to hurt himself/herself? If yes, please describe:_____

_____

☐ Yes ☐ No Has your child ever had thoughts, made statements, or attempted to hurt anyone else? If yes, please describe:_____

_____

☐ Yes ☐ No Has your child recently been physically hurt or threatened by someone ? If yes, please describe:_____

_____

Legal Matters	**Who:**
Current Legal Status:	
Charges:	
Probation:	
Custody Issues:	
Restraining Orders**:**	

Therapist:
Initial:

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Name:_____ Date:_____

FAMILY AND DEVELOPMENTAL HISTORY

Relationship	Name	Age	Quality of Relationship	Family Mental Health Problems	Who?
Mother				**Hyperactivity**	
Father				**Sexually Abused**	
Stepmother				**Depression**	
Stepfather				**Manic Depression**	
				Suicide	
Siblings				**Anxiety**	
				Obsessive-compulsive	
				Panic Attacks	
				Anger/Abusive	
				Schizophrenia	
Grandmother				**Eating Disorder**	
Grandfather				**Alcohol Abuse**	
Other				**Drug Abuse**	

Are parents presently married? ☐ Yes ☐ No

Are parents temporarily separated ? ☐ Yes ☐ No

Are parents presently divorced? ☐ Yes ☐ No

Are there any step-parents? ☐ Yes ☐ No

Mother Remarried? Number of times_____

Father Remarried? Number of times_____

Who is the Child currently living with?

_____

_____

Please check if the child has experienced any of the following trauma or loss:

☐ Emotional Abuse ☐ Neglect ☐ Lived in a Foster Home

☐ Sexual Abuse ☐ Violence in the Home ☐ Multiple Family Moves

☐ Physical Abuse ☐ Crime Victim ☐ Homelessness

☐ Parent Substance Abuse ☐ Parent Illness ☐ Loss of a Loved One

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PEDIATRIC CLIENT INFORMATION FORM

Name:_____ Date:_____

BIRTH AND DEVELOPMENTAL HISTORY OF THE CHILD/TEEN

Did mother use any of the following during her pregnancy?

Alcohol ☐ Yes ☐ No
Tobacco ☐ Yes ☐ No
Drugs ☐ Yes ☐ No

Describe any problems during the pregnancy:_____

_____

Length of Pregnancy:_____

Describe any difficulties during the delivery:_____

_____

_____

Were there any medical problems noted at/or immediately following birth?_____

_____

_____

Please state the age at which your child/teen did the following. If you do not remember the exact age please give an approximate age:

MOTOR

Sat Alone:_____

Stood Alone:_____

Walked Alone:_____

Toilet Trained:_____

LANGUAGE

Started using single words (other than MAMA/DADA):

_____

Using (3) word sentences:_____

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PREVIOUS MENTAL HEALTH TREATMENT

Yes	No	Type of Treatment	When?	Provider/Program	Reason for Treatment
☐	☐	Outpatient Counseling			
☐	☐	Medication (mental health)			
☐	☐	Psychiatric Hospitalization			
☐	☐	Drug/Alcohol Treatment			
☐	☐	Self-help/Support Groups			

SUBSTANCE USE HISTORY

*****Only complete this section if your child is 13 years of age or older. However, if this section applies to the presenting problem of the child, please continue to complete this section in it's entirety.*****

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco	☐	☐			☐	☐		
Caffeine	☐	☐			☐	☐		
Alcohol	☐	☐			☐	☐		
Marijuana	☐	☐			☐	☐		
Cocaine/Crack	☐	☐			☐	☐		
Ecstasy	☐	☐			☐	☐		
Heroin	☐	☐			☐	☐		
Inhalants	☐	☐			☐	☐		
Methamphetamines	☐	☐			☐	☐		
Pain Killers	☐	☐			☐	☐		
PCP/LSD	☐	☐			☐	☐		
Steroids	☐	☐			☐	☐		
Tranquilizers	☐	☐			☐	☐		

☐Yes ☐No Has your child ever had withdrawal symptoms when trying to stop using any substances? If yes, please describe:_____

_____

☐Yes ☐No Has your child ever had problems with school, relationships, health, the law, etc. due to your (the parent) substance abuse? If yes, please describe:_____

_____

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MEDICATION INFORMATION

Please list any medication(s) being prescribed to your child by a physician:

Medication	Dosage	Date Prescribed	Reason	Prescribed By	Side Effects

Current over-the-counter medications (including vitamins, herbal remedies, etc.) taken by your child:

_____

_____

Does your child have any allergies and/or adverse reactions to medications? ☐ Yes ☐ No

If yes, please list:_____

_____

Therapist notes

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PEDIATRIC CLIENT INFORMATION FORM

Name:_____ Date:_____

EDUCATION INFORMATION

School presently attending:_____ Grade:_____

Attended Pre-School? ☐ Yes ☐ No

Attended Kindergarten? ☐ Yes ☐ No

Does he/she attend any special classes? ☐ Yes ☐ No

If yes, please list the type of class and why:_____

_____

Has he/she repeated any classes? ☐ Yes ☐ No

If yes, what grade and why:_____

_____

Does your child/teen have an IEP? ☐ Yes ☐ No

Does you child/teen have a 504 Plan? ☐ Yes ☐ No

Has he/she had any psychological testing performed by the school? ☐ Yes ☐ No

If yes, what test(s) and do you have a copy of the results?_____

_____

Has he/she ever been suspended and/or expelled? ☐ Yes ☐ No

If yes, when and why:_____

_____

How well does your child play?

	No Problem	Few Problems	Frequent Problems
Alone	☐	☐	☐
With Younger Children	☐	☐	☐
Children His/Her Own Age	☐	☐	☐

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Name:_____ Date:_____

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your child's social support network (check all that apply):

☐ Family ☐ Neighbors ☐ Friends ☐ Students ☐ Co-workers ☐ Support/Self-Help Group

☐ Community Group ☐ Religious/Spiritual Center (Which one_____)

To which cultural or ethnic group does your child belong?_____

If your child is experiencing any difficulties due to cultural or ethnic issues, please describe:

_____

_____

How important are spiritual matters to your child ?

☐ Not at all ☐ Little ☐ Somewhat ☐ Very much

Please describe your child's strengths, skills, and talents:_____

_____

_____

Describe your child's areas of interest or hobbies (art, books, physical fitness, etc.):_____

_____

_____

Therapist Notes:
Init: