Child/Adolescent Form

Identification Date: _____
Name: _____ Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____ Social Security #: _____
Date of Birth: _____ Age: _____ Gender: □ M □ F
How long have you lived at this address? _____
Mailing Address (if different from above): _____

How were you referred to Cascade Counseling? □ Myself □ Yellow Pages □ Relatives □ Friend □ Doctor/Hospital/Clinic □ Parent/Guardian □ School □ Teen Hotline □ Court/Judge/Lawyer □ Probation or parole officer □ Other agency (specify) _____
□ Other (specify) _____

Mother (circle) biological step adoptive _____
Place of employment: _____ Work phone: _____
Father (circle) biological step adoptive _____
Place of employment: _____ Work phone: _____
Guardian _____ Relation to patient _____
Place of employment: _____ Work phone: _____

Family Information
Family Structure (who lives in your current household): _____
_____
_____
What do you like best about your father? _____
What don't you like about him? _____
How do you get along with him? _____ Work Phone: _____
What do you like best about your mother? _____
What don't you like about her? _____
How do you get along with her? _____ Work Phone: _____
How do your parents get along with each other? _____
Which child are you in your family (oldest, youngest, etc.)? _____
How do you get along with your brother(s)? _____
How do you get along with your sister(s)? _____
Who are you closest to in your family? _____
Who do you have trouble getting along with in your family? _____
Has anyone in your family (including relatives) had problems with drugs or alcohol?
□ Yes □ No □ Don't Know Who? _____

Health Information
Rate your physical health: □ Very Good □ Good □ Average □ Poor
Date of last medical exam: _____ Physician's name: _____
Are you presently taking medication? □ Yes □ No What? _____
Prescribed by: _____ Phone#: _____
Primary Care Physician: _____ Phone#: _____

Educational Background
Are you enrolled in school and if so where? _____
What kind of grades do you usually get in school? _____
What do you like and dislike about school? _____
What kinds of problems do you have in school? _____

Please answer the following questions:
What is the main reason you are here? _____

_____

What have you done about it? _____

_____

What would you like us to do? _____

_____

Is there any other information you would like me to know about? _____

_____

Other Background Information

____ Fingernail biting
____ Frequent nightmares
____ Bedwetting
____ Sleepwalking
____ Excessive thirst
____ Frequent headaches
____ Blackouts or dizzy spells
____ Stuttering
____ Overtiredness
____ Nervousness
____ Easily distracted
____ Sudden secretiveness
____ Demands for negative attention
____ Extreme changes in personality
____ Stomach problems
____ Not completing homework
____ Fighting at school

____ Trouble breathing
____ Moodiness
____ Depression
____ Shyness
____ Thoughts or acts of hurting or killing others
____ Thoughts or acts of hurting or killing yourself
____ Feeling people are out to get you
____ Overly sensitive
____ Excessive crying
____ Homesickness or loneliness
____ Trouble remembering
____ Trouble concentrating
____ Can't sit still when required to do so
____ Trouble sleeping
____ Trouble getting along with teachers/students
____ Trouble getting along with parents or family members

Have you ever been sexually assaulted or touched in ways that made you uncomfortable?
 Yes No