

Therapist \_\_\_\_\_

File No. \_\_\_\_\_

(For office use only)

## SAMARITAN COUNSELING CENTER CHILD AND ADOLESCENT INITIAL INFORMATION

Please fill out this form as completely as you can. All information is confidential.

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

**Name of person completing this form:** \_\_\_\_\_

**Child's Name:** \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

Social Security No.: \_\_\_\_\_

School: Grade: \_\_\_\_\_ Teacher's Name: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Address: \_\_\_\_\_ Social Security: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Address: \_\_\_\_\_ Social Security: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_

*(Required)*

(Name)

(Relationship)

(Daytime Phone)

(Evening Phone)

**Religious Preference(s):** \_\_\_\_\_

Congregation(s) Attended: \_\_\_\_\_

**Who Referred You To The Samaritan Counseling Center?**

\_\_\_\_ Clergy \_\_\_\_ Doctor \_\_\_\_ Internet \_\_\_\_ Family/Friend \_\_\_\_ Attorney/Court \_\_\_\_ Insurance  
\_\_\_\_ School \_\_\_\_ Former Client \_\_\_\_ Media \_\_\_\_ Other - Please Specify \_\_\_\_\_

If the child's legal guardian is someone other than one or both parents, identify that person:

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

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

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

**Parents' Marital Status:**

\_\_\_Married \_\_\_Single \_\_\_Divorced \_\_\_Spouse Deceased \_\_\_Separated

If Divorced, Spouse Deceased, or Separated, how old was the child when this occurred: \_\_\_\_\_

**If Divorced, Who Has Legal Custody?**

\_\_\_Mother \_\_\_Father \_\_\_Joint \_\_\_Other

**Step Parent's Name:** (if applicable): \_\_\_\_\_

**Child's Resides:** With both parents \_\_\_\_\_ With mother \_\_\_\_\_ With father \_\_\_\_\_  
Other \_\_\_\_\_

**Siblings:**

Name	Age
_____	_____
_____	_____
_____	_____
_____	_____

**Payment Responsibility:**

- Insurance Provider: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_  
Social Security No. of Policy Holder: \_\_\_\_\_
- Self Pay
- Bill to third party: \_\_\_\_\_  
(name/address)

**Has Your Child Had Previous Therapy?** Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, with whom? \_\_\_\_\_ When? \_\_\_\_\_

**Is Your Child Currently Taking Any Medications?** Yes \_\_\_\_\_ No \_\_\_\_\_

Medication(s): \_\_\_\_\_

For what?: \_\_\_\_\_

Prescribed by: \_\_\_\_\_

Length of time on medication: \_\_\_\_\_

**Please State Briefly The Concerns That Bring Your Child To Counseling:**

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**Please Check The Items Below That Describe Or Relate To The Concerns Mentioned Above:**

Eating problems		Sad, tearful	
Soiling of clothing, bedding		Loss of interest or pleasure in activities	
Wetting of clothing, bedding		Feeling worthless, guilty	
Sleep problems		Suicidal thoughts	
Bad dreams, nightmares		Suicidal behavior	
Sleepwalking		Self-harm	
Under active		Mood swings	
Overactive		Panic attacks	
Speech problems		Afraid	
Vocal tics		Worries	
Selectively mute		Separation anxiety	
Stuttering		Aggressive	
Hair pulling		Anger	
Motor tics		Irritable	
Odd, erratic, disorganized behavior		Argues	
Compulsive, repetitive behavior		Defiant	
Vague physical complaints		Drop in grades	
Pain		Behavior problems at school	
Preoccupied with being sick		Problems with other children	
Fakes being sick		Problems with teachers	
Body image problems		Relationship problems with parents	
Sexual problems		Drug use	
Gender confusion		Alcohol use	
Hears things that others do not		Breaks rules	
Sees things that other do not		Stealing	
Odd beliefs		Property destruction	
Obsessive thoughts		Fire starting	
Memory problems		Gambling	
Easily distracted		Cursing	
Impulsive		Lying	