Counseling Associates for Well-Being

Child/Adolescent Information

Please complete the following questions to the best of your ability. They are intended to assist us in providing the most informed care.

Demographic Information

Child's Name:_____

Social Security Number:_____ Birthdate:_____ Age:_____

Gender:_____ Race:_____ Spiritual Preference:_____

Parent/Guardian Contact Information

Name:_____

Address:_____

Home Phone:_____Work Phone:_____Cell or Other:_____

May we leave a message? YES_____NO_____ What is the best time to reach you?_____

Social Security Number:_____ Birthdate:_____ Age:_____

Briefly describe the main reason that you brought your child here for care:_____

_____

_____

Referred by: _____ Emergency Contact:_____
May we contact them to thank them for the referral? Y N

School Information

School Name:_____ Grade:_____

Teacher(s)' Name(s):_____

Has your child met with a school counselor or social worker? Y N If yes, what is his/her name:_____

_____

Would you like to sign a release of information allowing your child's therapist to contact the school for treatment planning purposes?_____

Family Information

Please list all parents/guardians:

Name Age Occupation

_____

_____

_____

_____

Number of child's siblings? _____

Please list their names and ages:_____

_____

Do any blood relatives of the child have any mental health or substance abuse problems?_____

Please describe:_____

_____

Health Information

Please provide the name, address and, phone number of your child's Primary Care Physician (if he/she has one):

Name:_____

Address_____

Phone:_____

Please list any medical problems or conditions for which your child is currently being treated:_____

_____

Please list any medications which your child is currently taking, including any herbal or over the counter medicines:_____

_____

Please list any medications your child has taken in the past that were prescribed to alleviate mental health symptoms: _____

Has your child previously received any counseling, psychotherapy or psychiatric care?_____

Please describe (when, what kind, by whom):_____

_____

_____

Personal Information

Name three words to describe your child:_____

Name three words to describe your parenting style: _____

Has your child ever been physically, emotionally, or sexually abused by anyone? Please briefly describe as much as you are comfortable: _____

_____

_____

Please describe any legal issues (for example custody, DJJ involvement) your child is currently or has previously been involved in: _____

_____

_____

Please describe your child's use of alcohol and/or drugs: _____

_____

_____

Do you consider your child to have a healthy relationship with food? _____
Describe:_____

_____

****
****
THIS SECTION FOR OFFICE USE ONLY
****

DSMIV DX:

Axis I:_____

AxisII:_____

Axis III:_____

Axis IV:_____

Axis V:_____

NOTES:_____

CHILD and ADOLESCENT ADDENDUM TO THE CLINICAL ASSESSMENT

PRENATAL, PERINATAL AND DEVELOPMENTAL EVENTS and HISTORY

- **PREGNANACY**

☐ Normal and routine

☐ Problematic _____

_____

_____

- **FETAL HEALTH prior to birth** Include **c**hild's exposure to substances during gestational development: amounts, frequency and duration _____

☐ Alcohol _____

☐ Illicit drugs _____

☐ Prescriptive medications _____

☐ Tobacco _____

☐ Caffeine _____

- **GESTATION:** Born at _____ weeks. Came home at _____ weeks.

- **BIRTH**

☐ **Routine delivery** ☐ Without complication
☐ With complications _____

_____

☐ **Cesarean delivery** ☐ Without complication
☐ With complications _____

_____

- **DEVELOPMENTAL HISTORY AND MILETONES**

	Within Normal Limits	**Notes-**(Grades, relationship with siblings, daycare, discipline)
Sat up	☐	
Pulled UP	☐	
Walked	☐	
Off Bottle	☐	
Used Cup	☐	
Fed self	☐	
Toilet Training	☐	
Spoke first word	☐	
Spoke in Sentences	☐	
Acclimated/transitioned to school	☐	
_____	☐	

- **PARENTAL CONCERNS OF NOTE** _____

_____

_____

_____

ALERT® Wellness Assessment - Youth

Completing this brief questionnaire will help us provide services that meet your child's needs. Answer each question as best you can and then review your responses with your child's clinician. Shade circles like this ●

Child's Last Name , First Name Child's Date of Birth: (mm/dd/yy) / /

Subscriber ID Authorization #

Clinician Last Name , First Name Today's Date: (mm/dd/yy) / /

Clinician ID/Tax ID Clinician Phone - State

MRef ○

Visit #: ○ 1 or 2 ○ 3 to 5 ○ Other

Relationship to child: ○ Mother ○ Father ○ Stepparent ○ Other Relative ○ Child/Self ○ Other

For questions 1-21, please think about your experience in the past week.

Fill in the circle that best describes your child:	*Never*	*Sometimes*	*Often*
1. Destroyed property	○	○	○
2. Was unhappy or sad	○	○	○
3. Behavior caused school problems	○	○	○
4. Had temper outbursts	○	○	○
5. Worrying prevented him/her from doing things	○	○	○
6. Felt worthless or inferior	○	○	○
7. Had trouble sleeping	○	○	○
8. Changed moods quickly	○	○	○
9. Used alcohol	○	○	○
10. Was restless, trouble staying seated	○	○	○
11. Engaged in repetitious behavior	○	○	○
12. Used drugs	○	○	○
13. Worried about most everything	○	○	○
14. Needed constant attention	○	○	○

How much have your child's problems caused:	*Not at All*	*A Little*	*Somewhat*	*A Lot*
15. Interruption of personal time?	○	○	○	○
16. Disruption of family routines?	○	○	○	○
17. Any family member to suffer mental or physical problems?	○	○	○	○
18. Less attention paid to any family member?	○	○	○	○
19. Disruption or upset of relationships within the family?	○	○	○	○
20. Disruption or upset of your family's social activities?	○	○	○	○

21. How many days in the past week was your child's usual routine interrupted by their problems? ☐ Days

Answer the following only if this is your first time completing this questionnaire for this child.

22. In general, would you say your child's health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

23. In the past 6 months, how many times did your child visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+

24. In past month, how many days were you unable to work because of your child's problems? *(answer only if employed)* ☐☐ Days

25. In the past month, how many days were you able to work but had to cut back on how much you got done because of your child's problems? *(answer only if employed)* ☐☐ Days

59243

Clinician: Please fax to (800) 985-6894

Rev. 2007