Rhea Fugal Counseling

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Individual, Family, & Child Therapy

Child/Adolescent Information Sheet

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information.

Child's Name: ____ Date:_________________

Birth date: _______/_______/_______ Age: __________ Gender ______________________________

Address: ____

City, State: ____ Zip: _____________________

Parent/ Guardian Name(s): ____

Home Phone: (____) ____________________________________ May I leave a message? □Yes □No

Cell/Other Phone: (____) _________________________________May I leave a message? □Yes □No

E-mail: ____ May I email you? □Yes □No
***Please note: Email correspondence is not considered to be a confidential medium of communication.**

Referred by (if any): ____

School:________________________ Phone:__________ Teacher:______________ Grade: ________

How does your child do in school academically? ____

How does your child do in school behaviorally?____

Does your child have a learning or physical disability? __Y, __N, __Maybe. Specify: _______________

____

Does your child have a mental health diagnosis? __Y, __N, Specify: ____________________________

____

Does your family have specific spiritual beliefs? ____

____

Medical History

During pregnancy, did mother use: __ Cigarettes, __ Alcohol, __ Drugs, __ Experience Extreme Stress?

Specify frequency, amounts, and duration: ____

List any birth complications (Ex: Premature, jaundice, C-section, etc.)___________________________

____

List any Medical conditions or history (Ex: Surgeries, broken bones, allergies, etc.)_________________

____

Does child use: __ Cigarettes, __ Alcohol, __ Drugs

Specify amount and frequency: ____

Primary Care Physician: __________________________ **Phone:**___________ **Last seen on:** _______

Psychiatrist: ____________________________________ **Phone:**___________ **Last seen on:** _______

Current medications: (Include dosage and frequency):_______________________________________

____

Medication Allergies: ____

Other Allergies: ____

In the first two years, did your child experience: __Separation from mother __Out of home care, __Disruption in bonding __Depression of mother __Abuse __Neglect __Chronic pain __Chronic Illness __Parental Stress

If yes, please specify: ____

____

Reached developmental milestones: __On time, __Early, __Late

How many times has the child moved homes? ____

What are five adjectives that describe:

Mother: ____

Father: ____

Child: ____

Parental Relationship: ____

Family History

Biological Dad:___________________________________ **age:**_____________________

Biological Mom:__________________________________ **age:**_____________________

_____ Married; _____ Separated; _____ Divorced

Siblings (1st to last):

Name: ___________________________ **Age:**____ **Name:** _________________________ **Age:** ____

Name: ___________________________ **Age:**____ **Name:** _________________________ **Age:** ____

Name: ______________________________ Age:____ Name: ___________________________ Age: ____

Custodial Adults (If not biological parent):

Name: ___________________________________ age: ________

Name: ___________________________________ age: ________

Date became caretaker: ____________

People in household, if different from above: ____

____

Does father work outside of the home? __Y, __N; Occupation: ______________________

Does mother work outside of the home? __Y, __N; Occupation: ____________________

If separated or divorced, visitation schedule: ____

What is custody arrangement regarding physical and mental health care: ____________________________

____

Does either parent have legal issues? ____

List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.): __________________

____

____

Have children witnessed domestic violence? __Y, __N, Specify: __________________________________

____

How is your child disciplined? Please list each method and frequency of use: ______________________

____

____

Trauma History

Has your child been verbally abused? __Y, __N, __Suspected. Specify: ____________________________

____

Has your child been physically abused? __Y, __N, __Suspected. Specify: __________________________

____

Has your child been sexually abused? __Y, __N, __Suspected. Specify: ____________________________

____

Other stressors or traumas? ____

Circle the symptoms your child/adolescent displays and list the number of times per week it is displayed:

Anger
Anxiety
Bed wetting
Acts out sexually
Conduct problems
Controlling Defecation
Has unusual sexual knowledge
Day wetting
Defiance
Depression
Homicidal thoughts
Disassociates actions
Drug or alcohol use
Hyperactivity
Masturbates excessively
Hyper vigilance
Impaired conscience
Isolation
Lack of empathy
Lack of motivation
Lethargy
Low impulse control
Plays out violent themes
Low self-esteem
Lying
Nightmares
Plays out sexual themes
Obsesses
Over/Under eating
Peer problems
Phobias
Running Away
Shy
Sleeplessness
Stealing
Tantrums
Somatic Symptoms: Headaches/Stomachaches, etc.

Other: ____

How does your child/adolescent handle anger? ____

____

Has the child/adolescent experienced any significant loss? If yes, explain: _________________________

____

What do you view as your child/adolescent's major strengths and positive traits?_____________________

____

What are your child/adolescent's hobbies? ____

____

What are your child/adolescent's responsibilities at home? ______________________________________

____

How well does your child/adolescent's handle these responsibilities? _______________________________

____

Goals and Emergency Contact Information.

Briefly describe your goals for your child/adolescent's therapy: ___________________________________

____

____

____

Please list any information you deem to be important for the therapist to know: _____________________

____

____

____

Who should I contact in case of emergency?

Name: ______________________________________

Phone (______)_______________________ Relationship _____________________________

In this box, please indicate the address and telephone number you want me to use to when sending bills or when I need to contact you. If this box is left blank, I will use the address and any of the telephone numbers you have provided above.

If you do *not* want me to leave a message on your answering machine, please tell me how you want me to reach you by phone:

I hereby consent for Rhea W. Fugal, LCSW, RPT to provide my child/adolescent with evaluation and treatment.

____

Signature **Date**