

Rhea Fugal Counseling

Licensed Clinical Social Worker, Registered Play Therapist

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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): Dad: _____ age: _____

Mom: _____ 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
Lack of empathy
Low impulse control
Lying
Obsesses
Phobias
Sleeplessness
Somatic Symptoms: Headaches/Stomachaches, etc.

Impaired conscience
Lack of motivation
Plays out violent themes
Nightmares
Over/Under eating
Running Away
Stealing

Isolation
Lethargy
Low self-esteem
Plays out sexual themes
Peer problems
Shy
Tantrums

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