For Office Use Only: _____
Therapist Date

Child/Adolescent Client Information

Demographic Information: Date: _____

Child's Full Name_____

Address_____

City_____State_____ Zip_____

Date of Birth_____ Age_____ Sex_____

Parent with whom child lives: Both _____ Mother _____ Father _____

Mother's Name_____

Address_____

City_____State_____ Zip_____

Home Phone_____ Yes _____ No_____ Ok to leave messages?
Cell Phone_____ Yes _____ No_____ Ok to leave messages?
Work Phone_____ Yes _____ No_____ Ok to leave messages?
Email Address_____ Yes _____ No_____ Ok to leave messages?

May we send you Cornerstone's email newsletter with resources for clients at no charge?_____

Occupation_____ Employer_____

Date of Birth_____

Father's Name_____

Address_____

City_____State_____ Zip_____

Home Phone_____ Yes _____ No_____ Ok to leave messages?
Cell Phone_____ Yes _____ No_____ Ok to leave messages?
Work Phone_____ Yes _____ No_____ Ok to leave messages?
Email Address_____ Yes _____ No_____ Ok to leave messages?

May we send you Cornerstone's email newsletter with resources for clients at no charge?_____

Occupation_____ Employer_____

Date of Birth_____

How did you find out about Cornerstone?_____

Referral Source_____

May we thank them for the referral? yes_____ no_____

Presenting Problem:
Please describe your concerns about your child and the reasons why you are seeking help.

_____
_____
_____
_____

Has your child received any type of previous counseling? If so, for what reasons, when and what was the outcome?

_____
_____
_____

Please rate on a scale of 1 to 10 (1=somewhat concerned and 10=very concerned) and note whether the problem is past or present concern

Problem	**Rating**	**Problem**	**Rating**
Sadness		Withdrawn	
Irritable		Crying Spells	
Suicidal Thoughts		Suicide Attempts	
Self-Harming		Head Banging	
Isolation		Rocking	
Increased Appetite		Sleeping More	
Decreased Appetite		Sleeping Less	
Change in Weight		Puts self down	
Destroys Property		Physical Aggression	
Verbal Threats		Disobeys Authority	
Cruelty to Animals		Stealing	
Trouble with the Law		Temper Tantrums	
Episodes of Rage		Mood Swings	
Lying		Running Away	
Drug/Alcohol Use		School Problems	
Truancy		Impulsive	
Short Attention Span		Easily Distracted	
Daydreaming		Hyperactive	
Problem	**Rating**	**Problem**	**Rating**
Lacks Initiative		Clumsy	
Stubborn		Shy	
Fearful		Lonely	
Difficulty with Peers		Frequent Illness	
Immature for age		Sexual Acting Out	
Bed Wetting		Soiled Pants	
Nightmares		Thumb sucking	
Rituals		Repetitive Movements	

Comments_____
_____
_____

Family History:
Child lives with: ___Both Parents ___Mother ___Father ___Other_____
If adopted or foster care, age that child began living with you_____

_____
Client Name

How would you describe the emotional relationship between child and:

Mother:_____
_____
_____

Father:_____
_____
_____

History of Parent's Relationship: (Date all that apply)
Married_____ Separated_____ Divorced_____ Deceased_____
Remarried to each other____ Living together but never married_____Parent's never lived together_____

If Step-Parent(s):
1) Name_____ Occupation_____Child Calls_____
Date Married_____ Relationship with Child_____
2) Name_____ Occupation_____ Child Calls_____
Date Married _____ Relationship with child_____

Siblings/Step-Siblings:

Name	**Age**	**Lives With**	**Relationship With Child**

Please check if there is a family history of any of these issues:

Issue	**Mother's Family**	**Father's Family**	**Step-Parent**	**Adopted or Foster Family**	**Others in home**
Mental Illness					
Drug Abuse					
Alcohol Abuse					
Physical Abuse					
Sexual Abuse					
Emotional Abuse					
Multiple Moves					
Financial Strain					
Parental Absence					
Criminal Offenses					
Eating Disorders					
Death of Close Family Member					

Developmental History:
Describe any difficulties with pregnancy and labor_____
_____
_____
_____
_____
_____

_____
Client Name

Has this child had any problems in motor development (such as difficulty learning new skills, poor coordination, difficulty coloring, writing, or using scissors?)

_____
_____
_____

Has this child had any difficulty with understanding or speaking language?

_____
_____
_____

Were there any difficulties with toilet training?

_____

Medical History:
Please describe this child's general health:

_____
_____
_____

Has this child had any serious illness, accidents, or injuries?

_____
_____

Please give reasons and approximate dates for any hospitalizations and emergency room visits:

_____
_____
_____
_____

Are there any conditions that require regular medical care?

_____
_____

List any medications child currently takes:

_____

List any allergies child has:

_____

Are immunizations up-to-date? _____ Date of last physical examination: _____
Results:

_____

Name of primary care physician: _____ Phone Number_____

Learning Development:
Current School_____ Grade_____

Briefly describe, in your opinion, how this child is doing in school behaviorally.

_____
_____
_____

_____
Client Name

Are there any identified delays, or disabilities in any area?
_____
_____
_____

Please explain if this child has:

- Had extended or frequent illnesses:
  _____
- Had to repeat a year:
  _____
- Changed schools in mid-year:
  _____
- Began school year at a new school:
  _____
- Had conduct problems: _____

Social Development and Peer Relationships:

In groups is your child usually: A leader ___ A follower ___ A loner ___
Does this child have problems making or keeping friends? ___ If yes, explain:
_____

Emotional Development:
List the strengths and positive qualities in this child:
_____
_____
_____

List the weaknesses or problematic characteristics in this child:
_____
_____
_____

Check all that apply to your child:

Humorous___ Shy___ Fun to be around ___ Restless___ Cheerful___ Lacks confidence___
Inattentive___ Abusive___ Quick to anger___ Sneaky___ Sad__ Creative___ Doesn't complete work___
Untruthful__ Daydreamer___ Insecure__ A complainer___ Aggressive__ Immature___ Talented__
Disruptive___ Quiet__ Disobedient___ Nervous/Tense___ Friendly___ Mean to others___ Lazy___
Imaginative___ Messy___ Kind___ Worrier___ Fearful___ Resilient___ Loud___ Forgetful___ Cruel___
Mature for age___ Unmotivated___ Hard worker___ Stubborn___ Gives up easily___ Careless___
Helpful___ Considerate___ Criticizes Others___ Motivated___ Sweet___ Uncaring___
Conscientious___

Relationships at Home:
Describe this child's behavior at home:
_____
_____

_____
Client Name

What special activities do you do with this child?

_____

What activities does the family unit do together?

_____

What are the parents'/guardians' goals for the children and family?

_____

_____

What are the chores assigned to this child, and what incentive is used to get the child to complete them?

_____

_____

What forms of discipline are used?

_____

_____

Please list any additional comments that you feel are important:

_____

_____

_____

_____ _____

Parent/Guardian Signature: Date:

_____

Client Name