**KARITAS COUNSELING**
**CHILD/ADOLESCENT CLIENT INFORMATION**

Welcome to Karitas Counseling. We ask your cooperation in filling out the following forms. This information is confidential and will assist your therapist in assessing your needs.

**Today's Date** _____ **Preferred Language** ☐ English ☐ Spanish

**Client's Name:** _____ **Birth Date** _____ **Age** _____

**Gender** ☐ Male ☐ Female **Social Security #** _____ **Parent/Guardian:** _____

**Address** _____
Street Address Apt # City State Zip Code

May we send mail at this address? ☐ Yes ☐ No

**Home Phone** (___) _____ May we leave a message? ☐ Yes ☐ No

**Work Phone** (___) _____ May we leave a message? ☐ Yes ☐ No

**Mobile Phone** (___) _____ May we leave a message? ☐ Yes ☐ No

**Email** _____ May we email you? ☐ Yes ☐ No Please be aware that email may not be confidential.

Would you like a reminder for your appointments?
☐ **NO**, I will remember appointment. OR ☐ **YES**, send me reminder by ☐ Text to #_____
☐ Call to #_____ ☐ Email to _____

**Who can we thank for referring you?** ☐ Self ☐ Friend ☐ Family Member ☐ Medical Doctor: _____
☐ Psychiatrist: _____ ☐ Other: _____

**Emergency Contact:** Who should we contact in case of an emergency?
Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____

**Insurance Company Information:**
**Ins Co. Name:**_____ **Phone Number:**_____
**Policy/ID:**_____ **Group Number:**_____

**Policy Holder Information:** (Complete section below IF policy holder is not client)
**Policy Holder Name:**_____ **Date of Birth:**_____
**Address:**_____ **Phone #:**_____
**Employer:**_____ **Gender** ☐ Male ☐ Female **Social Security #** _____
Client relationship to Policy Holder: ☐ Spouse ☐ Child ☐ Other: _____

**Secondary Insurance Company Information:**
**Ins Co. Name:**_____ **Phone Number:**_____
**Policy/ID:**_____ **Group Number:**_____

**Employee Assistance Program:**
**Ins Co. Name:**_____ **Phone Number:**_____
**Authorization #:**_____ **# Sessions Authorized:**_____ **Expiration Date:**_____

If no insurance or EAP, how will you pay for services? _____

**Client or Authorized Person's Signature:**
I authorize the release of any medical or other information necessary to process all insurance claims and authorize the use of this signature on all insurance submissions by Karitas Counseling. I authorize payment of medical benefits to Karitas Counseling and/or the provider.

Signature:_____ Date:_____

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Briefly describe the reason for your visit today: _____

_____

_____

Please check all your child's behaviors and symptoms that you consider problematic:

| | | | |
|---|---|---|---|
| ☐ Distractibility | ☐ Change in appetite | ☐ Visual hallucinations | ☐ Manipulative behavior |
| ☐ Hyperactivity | ☐ Withdrawal from people | ☐ Defiance | ☐ No/few friends |
| ☐ Impulsivity | ☐ Anxiety/worry | ☐ Aggression/fights | ☐ Eating problems |
| ☐ Boredom | ☐ Panic attacks | ☐ Homicidal thoughts | ☐ Sleep problems |
| ☐ Nightmares | ☐ Poor memory/confusion | ☐ Fear away from home | ☐ Frequent arguments |
| ☐ Sadness/depression | ☐ Social discomfort | ☐ Irritability/anger | ☐ Toileting problems |
| ☐ Hopelessness | ☐ Peer/sibling conflict | ☐ Fire setting | ☐ Phobias |
| ☐ Stealing | ☐ Thoughts of death | ☐ Obsessive thoughts | ☐ Work/school problems |
| ☐ Self-harm behaviors | ☐ Compulsive behavior | ☐ Destroys property | ☐ Legal Problems |
| ☐ Crying spells | ☐ Racing thoughts | ☐ Running away | ☐ Sexual behavior |
| ☐ Loneliness | ☐ Wide mood swings | ☐ Swearing | ☐ Computer addiction |
| ☐ Low self-worth | ☐ Suspicion/paranoia | ☐ Curfew violations | ☐ Alcohol/drug use |
| ☐ Fatigue | ☐ Hearing Voices | ☐ Lying | ☐ Lack of motivation |
| ☐ Recurring, disturbing memories | | ☐ Other: _____ | |

Are your child's problems affecting any of the following?

| | | | | |
|---|---|---|---|---|
| ☐ Handling everyday tasks | ☐ Self esteem | ☐ Relationships | ☐ Hygiene | ☐ Health |
| ☐ Recreational activities | ☐ Work/School | ☐ Legal matters | ☐ Housing | ☐ Finances |

Has your child ever had thoughts, made statements, or attempted to hurt him/herself or someone else? ☐ No ☐ Yes, please describe: _____

_____

Has your child recently been physically hurt or threatened by someone else? ☐ No ☐ Yes, please describe: _____

_____

_____

What are your 3 main treatment goals that you would like to accomplish in therapy?

1. _____
2. _____
3. _____

**Family History:**

Relationship Status of Parents:

☐ Cohabitating ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are the parents of the child separated or divorced? ☐ No ☐ Yes. If yes, what is the current child custody/visitation arrangement? _____

If yes, is either biological parent remarried? ☐ No ☐ Yes

Is your child currently the subject of a custody case? ☐ No ☐ Yes, please describe. _____

Who has legal custody of the child? _____ Is this Temporary? ___ OR Permanent? _____

Has the child lived with both parents since birth? ☐ Yes ☐ No, list changes chronologically (include other placements):

| From: | To: | Age: | Child lived with: |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

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Please complete the following section for each Parent:
Parent Name: _____ Age: _____ Occupation: _____
Employer: _____ Education: _____
How is this child disciplined by this parent? _____
What are the reasons the child is disciplined by this parent? _____

Parent Name: _____ Age: _____ Occupation: _____
Employer: _____ Education: _____
How is this child disciplined by this parent? _____
What are the reasons the child is disciplined by this parent? _____

| **Relationship** | **Name** | **Age / Gender** | **Lives with child?** | **Quality of relationship poor / average / good** |
|---|---|---|---|---|
| Stepmother | | | | |
| Stepfather | | | | |
| Siblings: | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Other relatives | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| **Family Mental Health Problems** | **Who?** |
|---|---|
| Hyperactivity | |
| Sexually abused | |
| Depression | |
| Bipolar | |
| Suicide | |
| Anxiety | |
| Panic Attacks | |
| Obsessive-Compulsive | |
| Anger/Abusive | |
| Schizophrenia | |
| Eating Disorder | |
| Alcohol Abuse | |
| Drug Abuse | |

**Pregnancy/Birth:**
Was the pregnancy with child planned? ☐ No ☐ Yes Length of pregnancy: _____
Birth Weight: _____ Type of Delivery: ☐ Cesarean ☐ Breech ☐ Normal ☐ Other: _____
Mother's age at child's birth: _____ Other Parent/Father's age at child's birth: _____
Child was number _____of ____total children.
While pregnant did the mother smoke? ☐ No ☐ Yes, what amount: _____
Did the mother use drugs or alcohol? ☐ No ☐ Yes, what amount/type: _____
While pregnant did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication, etc)
☐ No ☐ Yes, describe: _____
Describe any physical or emotional complications with the delivery: _____
_____
Describe any complications for the mother or the baby after the birth: _____
_____

**Infancy / Toddlerhood** (0-3 years) Check all that apply:
☐ Did not enjoy cuddling ☐ Difficult to comfort ☐ Excessively active ☐ Excessive restlessness
☐ Colic ☐ Head banging ☐ Diminished sleep ☐ Constantly into everything
☐ Problems with nursing/bottle ☐ Withdrawn/fearful ☐ Was not calmed by being held or stroked
☐ Cranky/irritable ☐ Irregular patterns of sleep, appetite, habits

**Developmental History:** Was your child on time, early or late in reaching these developmental milestones?

| | On time | Early | Late | | On time | Early | Late |
|---|---|---|---|---|---|---|---|
| Sat up | ☐ | ☐ | ☐ | Dry during day | ☐ | ☐ | ☐ |
| Walked | ☐ | ☐ | ☐ | Dry during night | ☐ | ☐ | ☐ |
| Talked | ☐ | ☐ | ☐ | Reading | ☐ | ☐ | ☐ |

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**PREVIOUS MENTAL HEALTH TREATMENT**

| Yes | No | Type of Treatment | When? | Provider/Program | Reason for Treatment |
|---|---|---|---|---|---|
| | | Outpatient Counseling | | | |
| | | Medication (Mental Health) | | | |
| | | Psychiatric Hospitalization | | | |
| | | Drug/Alcohol Treatment | | | |
| | | Self-help/Support Groups | | | |

Does your child have a Psychiatric Advance Directive (PAD)/Crisis Plan? ☐ Yes ☐ No
Have your child been the victim or at risk for domestic violence, emotional, physical or sexual abuse? ☐ No ☐ Yes, please describe: _____

Other trauma or losses: _____
_____

**EDUCATION**

Current grade: _____ School Name: _____

Has your child ever been held back in school? ☐ No ☐ Yes, describe: _____

**Current** grades: ☐ Excellent ☐ Good ☐ Fair ☐ Poor **Past** grades: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
**Current** conduct: ☐ Excellent ☐ Good ☐ Fair ☐ Poor **Past** conduct: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Has your child had any of the following difficulties this year in school?

| | | | |
|---|---|---|---|
| ☐ Suspension | ☐ Incomplete homework | ☐ Learning problems | ☐ Referrals or detentions |
| ☐ Poor grades | ☐ Teased or picked on | ☐ Speech problems | ☐ Attendance Problems |
| ☐ Gang influence | ☐ Special/modified education | ☐ Skipping | ☐ Difficulty making friends |

Which subjects does your child enjoy in school? _____
Which subjects does your child dislike in school? _____
Has your child been tested psychologically? ☐ No ☐ Yes, describe: _____

**Feelings about School Work:**
☐ Anxious ☐ Passive ☐ Enthusiastic ☐ Fearful ☐ Eager ☐ No expression
☐ Bored ☐ Rebellious ☐ Other, describe: _____

**Approach to School Work:**
☐ Organized ☐ Responsible ☐ Interested ☐ Self-directed ☐ No Initiative ☐ Refuses
☐ Sloppy ☐ Disorganized ☐ Cooperative ☐ Does only what is expected ☐ Does not complete assignments
☐ Other, describe: _____

**Performance in School:**
☐ Satisfactory ☐ Underachiever ☐ Overachiever ☐ Other, describe: _____

**Child's Peer Relationships:**
☐ Spontaneous ☐ Follower ☐ Leader ☐ Difficulty making friends ☐ Makes friends easily
☐ Long-time friends ☐ Shares easily ☐ Other, describe: _____

If your child is involved in a vocational program or works a job, please fill in the following:
What is your child's attitude toward work? ☐ Poor ☐ Average ☐ Good ☐ Excellent
Current Employer: _____ Position: _____ Hours per week: _____
How have your child's grades in school been affected since working? ☐ Lower ☐ Same ☐ Higher
How many previous jobs or placements has your child had? _____

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**SUBSTANCE USE HISTORY (for ages 12 and older or if applicable)**

☐ None

| | **Current Use (last 6 months)** | | | | **Past Use** | | | |
|---|---|---|---|---|---|---|---|---|
| **Substance Type** | Y | N | Frequency | Amount | Y | N | Frequency | Amount |
| Tobacco | | | | | | | | |
| Caffeine | | | | | | | | |
| Alcohol | | | | | | | | |
| Marijuana | | | | | | | | |
| Cocaine | | | | | | | | |
| Heroin/Opioids | | | | | | | | |
| Amphetamines | | | | | | | | |
| Hallucinogenic | | | | | | | | |
| Prescription | | | | | | | | |
| Other: | | | | | | | | |

| **The CRAFFT Screening (for ages 12+ or if applicable)** | **Yes** | **No** |
|---|---|---|
| During the PAST 12 MONTHS, did you: | | |
| 1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.) | | |
| 2. Smoke any marijuana or hashish? | | |
| 3. Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff") | | |

What are the minor's reasons for using? (e.g. addicted, build confidence, escape, social, medicate, etc.) _____

_____

Does the minor believe substance use is a problem? ☐ No ☐ Yes, please describe: _____

_____

Has your child had withdrawal symptoms when trying to stop using any substances? ☐ No ☐ Yes, please describe: _____

_____

Has your child ever had problems with work, relationships, health, the law, etc. due to his/her substance use?
☐ No ☐ Yes, please describe: _____

**MEDICAL INFORMATION**

How would you describe your child's physical health? ☐ Good ☐ Fair ☐ Poor Date of Last physical exam: _____
Allergies: _____ Date of Last Eye Exam: _____

Indicate which of the following medical conditions **currently** affect your child.

| | | | | |
|---|---|---|---|---|
| ☐ Asthma | ☐ Headaches | ☐ Stomach aches | ☐ Head injury | ☐ Seizures |
| ☐ Chronic Pain | ☐ Surgery | ☐ Serious accident | ☐ Abortion | ☐ Diabetes |
| ☐ Vision Problems | ☐ Meningitis | ☐ Dizziness/fainting | ☐ Thyroid Disorder | ☐ Cancer |
| ☐ Hearing problems | ☐ Sleep disorder | ☐ Sexually transmitted disease | ☐ Other: _____ | |

Please list any CURRENT health concerns: _____

List current medications and over-the-counter: ☐ None

| Medication | Dosage | Date first prescribed | Reason | Prescribed by |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Current over-the-counter medications (including vitamins, herbal remedies, etc.): _____

_____

Physician's Name: _____ Phone: _____
Would you like your therapist to coordinate care with your child's pediatrician? ☐ Yes ☐ No

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**INTERPERSONAL/SOCIAL/CULTURAL INFORMATION**

Please describe your child's social support network (check all that apply):
☐ Family ☐ Neighbors ☐ Friends ☐ Co-workers ☐ Support/Self-help Group ☐ Community Group
☐ Religious/Spiritual Center: (which one?) _____

How would your child identify his/her sexual orientation? ☐ straight/heterosexual ☐ lesbian/gay/homosexual ☐ bisexual ☐ transsexual ☐ unsure/questioning ☐ asexual ☐ other: _____ ☐ prefer not to answer
**Race:** ☐ White ☐ Black or African American ☐ Asian ☐ Other _____
**Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other _____

If your child is experiencing any difficulties due to cultural or ethnic issues, please describe: _____

How important are spiritual matters to your child? ☐ Not at all ☐ Little ☐ Somewhat ☐ Very much

Would you like spiritual/religious beliefs to be incorporated into your child's counseling? ☐ No ☐ Yes, please describe.

Are you satisfied with your current social life? ☐ No ☐ Yes, please describe. _____

Please describe your child's strengths, skills and talents? _____

Describe any special areas of interest or hobbies (art, books, physical fitness, etc.): _____

**LEGAL INFORMATION**

Has your child ever been a ward of the court with DFPS / CPS guardianship? ☐ No ☐ Yes, please describe. _____

Does your child have any legal offenses on record or pending in the courts? ☐ No ☐ Yes, please describe. _____

**For Therapist Use Only:**

**MSE: Orientation:** ☐ Time ☐ Person ☐ Place **General Appearance:** ☐ Neat ☐ Unkempt ☐ Bizarre
**Mood:** ☐ Relaxed ☐ Anxious ☐ Fearful ☐ Suspicious ☐ Depressed ☐ Irritable ☐ Angry ☐ Euphoric ☐ Guarded
**Affect:** ☐ Appropriate/Congruent ☐ Inappropriate ☐ Blunted ☐ Flat ☐ Constricted ☐ Expansive
**Speech:** ☐ Rapid ☐ Slow ☐ Ordinary ☐ Hesitant ☐ verbose ☐ Mute ☐ Loud ☐ Soft ☐ Rambling ☐ Incoherent
**Cognition:** ☐ Easily distractible ☐ preoccupied ☐ denial ☐ sufficient
**Thought Patterns:** ☐ Coherent ☐ Confused ☐ Disorganized ☐ Delusional ☐ Tangential ☐ Other: _____
**Insight:** ☐ Good ☐ Limited ☐ Poor ☐ None **Judgment:** ☐ Good ☐ Fair ☐ Poor
**Risk Assessment:**
**Suicidal:** ☐ Current ☐ Ideation ☐ Plan ☐ Attempt(s) ☐ none disclosed
☐ Past ☐ Ideation ☐ Plan ☐ Attempt(s)
Please explain: _____
**Homicidal:** ☐ Current ☐ Ideation ☐ Plan ☐ Attempt(s) ☐ none disclosed
☐ Past ☐ Ideation ☐ Plan ☐ Attempt(s)
Describe: _____
**General Impression of risk to self or others:** _____
**Diagnostic Impression** (include dsm-v code): _____
**Recommendation(s)**: ☐ Individual counseling ☐ Family Counseling ☐ Substance abuse education
☐ Substance abuse counseling ☐ Parenting ☐ Domestic violence education ☐ Other: _____
**Suggested treatment plan goals**: _____

_____ _____
Clinician Signature and Title Date