Kathryn Lamermayer, LCSW
Individual, Couples and Family Therapy

Child/Adolescent Information Form

Child/ Adolescent name:_____

Reason for Referral:

Briefly state the main concerns for which you are presently seeking help for your child:

How long have you had the concerns about your child?

What things have you tried to correct these concerns?

What did you tell your child about coming here today?

Family Information:

Names of child's legal guardians:_____

Relationship to child:_____

Highest grade completed by mother:_____ Highest grade completed by father:_____

Mother's Occupation:_____Father's Occupation:_____

Parents' marital status: ___ Married ___Divorced ___ Separated ___ Never Married ___ Deceased

If the child's parents have been married, how long have they been married? _____

If separated or divorced, age of child at the time: _____ Dates of remarriages: _____

Frequency of visitation with non-custodial parent:_____

Please list all the members of your child's immediate family (include any half of step-siblings):

Name:	DOB	Age	Relationship to Child	Living within household
_____	_____	_____	_____	Yes/No
_____	_____	_____	_____	Yes/No
_____	_____	_____	_____	Yes/No
_____	_____	_____	_____	Yes/No
_____	_____	_____	_____	Yes/No
_____	_____	_____	_____	Yes/No
_____	_____	_____	_____	Yes/No
_____	_____	_____	_____	Yes/No

Developmental History:

Concerns regarding your child's early development:

Does your child have any problems with going to sleep/staying asleep? Yes/No (describe):

Medical History:

	Circle One:	Ages	Describe
Allergies	Yes/No		
Appetite/Eating problems	Yes/No		
Asthma	Yes/No		
Clumsiness/poor motor skills	Yes/No		
Chronic Constipation	Yes/No		
Chronic ear infections	Yes/No		
Headaches	Yes/No		

Hearing/ear problems	Yes/No		
Head Injury	Yes/No		
Nightmares	Yes/No		
Persistent high fevers	Yes/No		
Physical disabilities	Yes/No		
Seizures	Yes/No		
Sleep apnea/snoring	Yes/No		
Surgeries	Yes/No		
Tics/Twitching	Yes/No		
Vision/eye problems	Yes/No		
Alcohol use/abuse	Yes/No		
Illicit drug use/ Abuse	Yes/No		
Risky behaviors	Yes/No		

Current Medications: Yes/No (if yes, please list)

Name of Medication: Dosage: Name of Prescribing Physician:

_____ _____ _____

_____ _____ _____

Difficulties following doctor's advice for medicine or other treatment: Yes/No (describe)

Notable childhood diseases: specify age and any complications:

Hospitalizations (describe):

Family history of medical problems (describe):

Family history of attention or learning difficulties (describe):

Family history of behavioral, emotional of psychological problems, including frequent use of alcohol or other substances to cope with stress (describe):

Psychiatric hospitalizations: Yes/No (describe):

History of medications: Yes/No (describe):

School History:

Name of current school:_____Phone:_____

Grade:_____Teacher:_____

Skipped grades: Yes/No Which ones? _____Reason:_____

Repeated grades: Yes/No Which ones?_____Reason: _____

Has a psychologist ever tested your child? (Yes/No) When/Why?:

Does your child receive any special education, enrichment or resource services? Yes/No (describe):

	Circle One:	Ages:	Describe:
Early Education Intervention	Yes/No		
Occupational Therapy	Yes/No		
Physical Therapy	Yes/No		
Speech Therapy	Yes/No		

Teachers report problems in: (please check any that apply)

Reading:_____ Attention/concentration:_____
Spelling:_____ Behavior: _____
Math:_____ Social Skills: _____
Writing:_____ Emotional adjustment: _____

Has your child ever received detention, been suspended or expelled? Yes/No (describe):

Previous schools attended	Dates attended (begin-end)
_____	_____
_____	_____
_____	_____

Briefly describe any problems occurring during your child's attendance at these previous schools:

Describe any concerns your child may have with peers (e.g., bullied, teased, no friends, poor social skills, aggressive, bossy, shy):

Is your child involved in any clubs, sports, or other organized activities: Yes/No (please list):

Please list some of your child's personal strengths and talents:

Please check any of the following stressful events that apply to your child or family and describe:

___ Re-locations:
___ Job Change:
___ Deaths:
___ Illnesses:
___ Martial Problems:
___ Job Changes:
___ Someone significant moving out of the area:
___ Experiencing a traumatic event:
___ Witnessing a traumatic event:
___ Physical or sexual abuse or neglect:
___ Division of Child and Family Services (DCFS) involvement:
___ Legal Issues:
___ Other:

Please write any other additional remarks you may wish to make regarding your child below. Thank you for taking the time to complete the information form.