



TRAVERSE COUNSELING & CONSULTING

Traverse: To pass over, along or through

General Client Information – Child & Adolescent

Today's Date: _____ Child's Name: _____

Date of birth: _____ Clinician child is seeing today: _____

Parent #1 Name: _____ Date of birth: _____

Cell phone number _____ Home phone #: _____

Complete Address: _____

Email: _____ Soc. Sec. #: _____

Employer: _____

Parent #2 Name: _____ Date of birth: _____

Cell phone number _____ Home phone #: _____

Complete Address: _____

Email: _____ Soc. Sec. #: _____

Employer: _____

(If parents have separate addresses, please put an * next to the address to use for billing.)

Are parents married? circle: Yes No Year of divorce/separation: _____

Legal Custody (circle) Joint Sole Who holds custody? _____

Am able to provide documentation. Yes No

Other children (names, ages): _____

Presenting Problem

1. What is/are the reason(s) you are seeking therapy today? _____

2. Did a specific event lead to this request for service? Yes No (If yes, please describe incident)

3. Please describe what you hope your child to accomplish in this therapy or what you hope will be different in their life as a result of attending therapy.



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4. How long has the problem been present? _____

5. What solutions to the problem have you tried, and what were the results? _____

6. How much does this problem affect your life? (Please circle the number that best applies)

| | Not at all | A little bit | Half the time | Almost/all the time |
|-----------------------|-------------------|---------------------|----------------------|----------------------------|
| Personally | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| Family life | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| Social/Friends | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| School | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |

7. How were you referred to this service? (circle) **Self Spouse/Other Court** _____
Physician (Clinic/Name) _____
School Counselor (Name/District) _____
Employer (Company/Name) _____
Other (specify): _____
8. Please list previous therapy experiences for your child and close family members. _____

9. Please list medical conditions that impact your child or close family members. _____

10. Please list current and past medications for your child: _____



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11. Does your family have involvement with any of the following services? Yes No (If yes, please circle all that apply.)

County Social Worker Probation Officer Adult/Child Protection Guardian Ad Litem

Parenting Consultant Parenting Time Expeditior Worker's Compensation School Counselor

If so, please describe. _____

12. **Are any of the following concerns affecting your family?** (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Family move to a new home | <input type="checkbox"/> Post-divorce adjustment | <input type="checkbox"/> Dishonesty |
| <input type="checkbox"/> Death of a family member | <input type="checkbox"/> Law violations | <input type="checkbox"/> Anger/Violence |
| <input type="checkbox"/> Alcohol/Substance | <input type="checkbox"/> Financial/employment stress | <input type="checkbox"/> Chronic illness |
| <input type="checkbox"/> Compulsive gambling/spending | <input type="checkbox"/> Developmental problems | <input type="checkbox"/> Mental Health Issues |
| <input type="checkbox"/> Birth of child or sibling | <input type="checkbox"/> Fighting with spouse | <input type="checkbox"/> Pornography use |
| <input type="checkbox"/> Adjustment to new job | <input type="checkbox"/> Parenting problems | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Suspect physical/sexual/emotional abuse | <input type="checkbox"/> Other trauma | <input type="checkbox"/> Hospitalizations/ER |
| <input type="checkbox"/> Substance misuse/abuse | <input type="checkbox"/> Marital unfaithfulness | <input type="checkbox"/> Previous therapy |
| <input type="checkbox"/> Incarcerated household member | <input type="checkbox"/> Career concerns/unemployment | <input type="checkbox"/> Spiritual issues |
| <input type="checkbox"/> Chronic Illness/Medical Condition | <input type="checkbox"/> Overinvolved family members | |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ | |

13. **Are any of the following resources and supports available to your child and family?** (Check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> extended family | <input type="checkbox"/> neighborhood supports | <input type="checkbox"/> peer friendships |
| <input type="checkbox"/> network of friends | <input type="checkbox"/> spiritual community | <input type="checkbox"/> school staff supports |
| <input type="checkbox"/> community-based support groups | <input type="checkbox"/> Flexibility in the family system | |
| <input type="checkbox"/> Ability of family members to positively influence each other | <input type="checkbox"/> Other: _____ | |



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14. If you parent with another adult, do you share similar parenting perspectives? Yes No

If no, are you able to reach agreement or resolve conflicts away from your child/ren? Yes No

Comments: _____

15. What interests, strengths, and passions give meaning to your child/ adolescent's life? _____

16. Are there any aspects of your culture, heritage, ethnicity, gender, sexuality or religion that you would like the therapist to be aware of? Yes No

17. Is there anything else that you would like the therapist to know and that you have not written about on any of these forms? Yes No

Filled out by

Date

Relationship to client

I acknowledge that the information on this form is accurate to the best of my knowledge, and that I will inform the therapist of any changes in my or my child's personal circumstances including address, symptoms experienced, suicidal thoughts and substance use.

Parent Signature

Date

Parent Signature

Date