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? ☐ **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)

_____

_____

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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.

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._____

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

_____

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

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

Parenting Consultant Parenting Time Expeditor Worker's Compensation School Counselor

Please describe. _____

_____

_____

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

___ Family move to a new home
___ Death of a family member
___ Alcohol/Substance
___ Compulsive gambling/spending
___ Birth of child or sibling
___ Adjustment to new job
___ Suspect physical/sexual/emotional abuse
___ Substance misuse/abuse
___ Incarcerated household member
___ Chronic Illness/Medical Condition
___ Other: _____

___ Post-divorce adjustment
___ Law violations
___ Financial/employment stress
___ Developmental problems
___ Fighting with spouse
___ Parenting problems
___ Other trauma
___ Marital unfaithfulness
___ Overinvolved family members
___ Career concerns/unemployment
___ Other: _____

___ Dishonesty
___ Anger/Violence
___ Chronic illness
___ Mental Health Issues
___ Pornography use
___ Surgeries
___ Hospitalizations/ER
___ Previous therapy
___ Spiritual issues

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

____ Close Extended family
____ Strong network of friends
____ Community-based support groups
____Ability of family members to positively influence each other
____ Neighborhood supports
____ Spiritual community
____ Flexibility in the family system
____Other: _____
____ Peer friendships
____ School Staff support

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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

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