

COGNITIVE THERAPY AND CONSULTING ASSOCIATES

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Child/Adolescent Information Form

Child/Adolescent Name _____

DOB ____ / ____ / ____ Age _____

Address _____

Phone (____) _____

Present Grade _____

Religion _____

Name of School _____

Birthplace _____

Referred by: Self Physician School Other (specify) _____

Family Information

Mother's Name _____

Father's Name _____

Address _____

Address _____

Home Phone _____

Home Phone _____

Work Phone _____

Work Phone _____

Occupation _____

Occupation _____

How long on present job _____

How long on present job _____

Length of time lived in this area _____

Length of time lived in this area _____

School grade completed _____

School grade completed _____

_Married yes no

_Married yes no

Years married _____

Years married _____

Do you live with your spouse yes no

Do you live with your spouse yes no

If married previously; give dates _____

If married previously; give dates _____

Birthplace _____

Birthplace _____

Religion _____

Religion _____

Military Service _____

Military Service _____

Household Members

Name	Age	Relationship to Child	Occupation/Grade

History

Describe the reasons that caused you to schedule an appointment _____

When did this begin? _____

Did you have any concerns about you child's early development? yes no

feeding sleeping talking walking toilet training other
please briefly explain any items checked _____

Was your child:

irritable good natured fussy difficult to comfort easy to comfort

Has your child had any significant medical problems? yes no

If yes please list:

Medical Problem	Date	On-going	Resolved

Has your child ever had psychotherapy or counseling before? yes no

If yes,

When: _____ Where: _____

Was it helpful? yes no

Has your child ever received any type of psychological or educational testing?

If yes,

When: _____ Where: _____

Has your child ever had medication prescribed for psychiatric or emotional difficulties? yes no

If yes, please list all medications:

Medication	Dosage	When (e.g., 6/01-2/02)	Prescribed for

What medications is your child currently taking?

Medication	Dosage	Frequency	Prescribed for

Has your child had difficulty at school? yes no

If yes, please briefly explain: _____

Signature of parent/guardian

Date