FSC Family Service Center
Help is Here

Child/Adolescent Information Form

Child/Adolescent's name: _____

Reason for Referral:

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

_____
_____
_____
_____
_____
_____
_____
_____

How long have you had these 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 ☐Deceased ☐Never Married

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

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

Frequency of visitation with non-custodial parent: _____

Please list all the members of your child's immediate family (include any half or stepsiblings):

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

Pregnancy and Development:

Was the pregnancy normal? Yes/No

(describe)_____

_____

Length of pregnancy (months) _____ Number of weeks early _____ or late _____

Type of delivery: ☐Vaginal ☐Breech ☐Cesarean ☐Forceps aided

Complications during labor or delivery? Yes/No (describe):_____

_____

Newborn difficulties ☐None ☐Cyanosis (turned blue) ☐Stay in NICU or special care nursery
Other: _____

Indicate age at which your child achieved the following:

Sat without support	_____	Spoke first words	_____
Crawled	_____	Put 2-3 words together	_____
Walked	_____	Said sentences	_____
Toilet trained	_____		

Concerns regarding your child's early development: Yes/No (describe): _____

_____

_____

_____

Concerns about feeding as infant: Yes/No (describe): _____
_____
_____
_____

Does your child have any problems with toileting? Yes/No (describe): _____
_____
_____
_____

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

Do you think your child is a danger to himself/herself or others? _____ Yes _____ No

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: Yes/No (describe): _____ _____

Family history of medical problems: (describe): _____ _____
_____
_____
Family history of attention or learning difficulties: (describe):_____
_____
_____

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

Please list counselors, psychotherapists, psychologists and psychiatrists who have seen your child:

Age Provider Name Service (testing, treatment, medication) Helpful
____ _____ _____ Yes/No
____ _____ _____ Yes/No
____ _____ _____ Yes/No
____ _____ _____ Yes/No

Psychiatric hospitalizations: Yes/No (describe): _____

History of medications for mood or behavior: Yes/No (describe):_____

School History:

Name of current school: _____ Phone: _____
Grade: _____ Teacher: _____ Present letter grades: _____
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? _____

*If yes, please bring a copy of the report to our office.

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		

*If your child receives any special education services, please enclose a copy of your child's current Individual Education Plan (IEP) or have it sent by the school.

Teachers report problems in:

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 problems 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:

- ☐ Relocations: _____
- ☐ Job change: _____
- ☐ Deaths: _____
- ☐ Illnesses: _____
- ☐ Marital 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 additional remarks you may wish to make regarding your child below. Thank you for taking the time to complete this information form.

_____
_____
_____
_____
_____