ACACIA CENTER FOR HUMAN GROWTH AND DEVELOPMENT, INC.

D. Shaner Gable, Ph.D., H.S.P.P. Carolyn B. Hines, M.Ed., Ph.D.

Child Client Information

Date ______________________

Basic Information

Last Name ______________________________ First Name, MI ________________________

Male / Female Date of Birth _____________________ SS# _________________________

Street Address ____

City _______________________________ State________________ Zip code ______________

Home phone __________________________ Cell phone _______________________________

Is the child a student? Yes / No

School ______________________________________ Grade __________________________

Primary Care Physician _________________________ Phone ___________________________

Insurance Information

Name of insurance company ____

Name of person who carries insurance ____

Date of birth of insurance carrier ____

Relationship to client ____

Group # _____________________________ ID# __________________________________

Emergency Contact

Name ____ Phone # _______________________

Relationship to client ____

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Health Information Form

(child or adolescent)

Name ____ Date of Birth __________________

Who referred your child to Acacia Center? ____

Current Problems

Please describe the problems you child is having.

____

____

____

When did these problems start? ____

Any previous counseling? Yes____ / No____

With whom? _______________________________ When? _____________________________________

Has your child recently had a major crisis? If so, what? ____

Has your child ever been abused? Yes_____ / No_____

If yes, was it emotional _____ physical _____ sexual _____ Was it reported? Yes____ / No____

Please explain ____

In the ***past month*** has your child been (please check all that apply):

[ ]sad, depressed, tearful [ ]seems not to enjoy anything [ ]seems tired, low energy

[ ]worries a lot, fearful, or anxious [ ]won't leave home or avoids others

[ ]criticizes self, low self-esteem [ ]irritable, gets upset easily [ ]angry or mean attitude

[ ]has trouble concentrating [ ]won't express or show feelings

[ ]keeps thinking of bad memories [ ]talks about hurting self or dying

How is your child's appetite? good____ / fair____ / poor____

Is your child on a special diet? yes____ / no____ Please explain_________________________________

Has your child's weight changed in the last six months? yes____ / no____

If so, has it increased ____ decreased ____ By how many pounds? _____

Client's Health History

Illnesses other than usual childhood illnesses ____

____

____

Any hospitalizations? yes____ no____ When? ____

Any surgeries?____

Any sleep or appetite problems? ____

Any serious accidents? ____

Any infectious diseases? yes____ / no____ If yes, please describe ______________________________________

Any allergies or adverse reactions? yes____ / no____ If yes, please describe ___________________________________

Pregnancy and Birth History

Adopted? yes____ / no____ Full tern? yes____ / no____

Please explain any problems with pregnancy/birth?____

____

Family History (mother/father)

Physical Illnesses ____

Learning Problems ____

Psychiatric Illnesses ____

Home Information

Mother _____________________________________ Age_________ Marital Status ________________

Education ______________________________ Occupation ________________________________

Place of Employment _________________________________ Phone __________________________

Father _____________________________________ Age__________ Marital Status ________________

Education ______________________________ Occupation ________________________________

Place of Employment _________________________________ Phone __________________________

Siblings – Name(s) and age(s)____

____

____

Who lives in home with child? ____

Is the family facing any major stresses? (Marital, Legal, Financial, Alcohol/Drugs, etc.)

____

Are there major conflicts in the home? (parent's or children arguing, custody/visitation conflicts, child support)

____

Has your child ever lived away from the family? yes____ / no____ When? __________________________

Is someone other than the parent your child's guardian? yes____ / no____ Who? _____________________

Is your child a ward of the Division of Family and Children? yes____ / no____ For how long? ___________

County:__________________________ Case worker: ______________________________________

Early Childhood

Please explain any unusual circumstances during the first five years? (separation/divorce, illness in child or family, deaths) ____

____

School Information

Name of school ____

Any problems at school? Explain ____

____

____

For Adolescents

Has your child ever used: cigarettes____ alcohol____ drugs____ What kind? _______________________

Has your child had any contact with: Police ____ Juvenile court ____ Probation officer ____

Please explain ____

Treatment Needs
If you child does not get help, what do you think will happen? Check all that apply.

Child will not be able to cope well ___
Child may fail or do poorly in school ___
Child may not be able to stay with family ___
Child may be victimized in some way ___
Child may harm self ___
Child may need to be placed in a hospital ___
Child may get in trouble with authorities ___
Child may run away from home ___
Family will be stressed ___
Family functioning may decrease ___
Child may harm someone else ___
Child may need special schooling ___
Other ___
Please explain ____

Will you be able to take part in your child's treatment? yes____ / no____
If no, why not?____
What outcome would you like to see from your child's therapy? ______________________________
____
____

Please list three of your child's strengths.
1.____
2.____
3.____

Please list three goals you have for your child's treatment.
1.____
2.____
3.____

Other History Information
____
____
____
____

Signature _________________________________ **Date** ____________________

THIS FORM WAS COMPLETED BY: PATIENT ____ THERAPIST ____ OTHER___________
REVIEWED BY THERAPIST ____