5500 Poplar Avenue
Suite 11
Memphis, TN 38119

PROTEA
COUNSELING & CONSULTATION GROUP, PLLC

Child/Adolescent Client Contact Form

Child's Name_____ Sex_____ Age_____ DOB_____

Natural Child Yes / No If adopted, at what age_____ Foster since _____

Parent's Names (include stepparents, foster parents, etc.)

_____

_____

Comments about custody and visitation (if applicable):

_____

_____

Daytime phone number where you wish to be reached regarding appointments: _____

Calls will be discreet, but please indicate any restrictions regarding calls:

_____

_____

Responsible Party (if other than client) _____

Relationship to Client _____Phone Number_____

Who referred you to us? _____ Date problems first noted _____

Date(s) of any previous therapy/treatment _____

Who provided the previous treatment? _____

Is your child currently seeing a psychiatrist, psychologist, or counselor? _____

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Has your child ever been hospitalized for a mental or emotional illness? _____

Name of Pediatrician _____ Phone Number_____

Pediatrician's Address _____

When was your child's last comprehensive medical evaluation? _____

Please list any medications your child is currently taking _____

_____

Special Note _____

ACADEMIC INFORMATION

Name of child's school _____ Grade_____

Typical Grades _____

Primary reason you are concerned about your child? _____

_____

_____

_____

Common problem/symptom checklist. Please check any symptom that is a concern.

___Sleep Problems	___Morbid thoughts	___Suicidal thoughts/threats
___Lack of interest in activities	___Suicidal plans/attempts	___Mood swings
___Fatigue/Low energy	___Depression	___Cries easily
___Concentration problems	___Aggressive behavior	___Irritable
___Appetite/Weight changes	___Can't sit still	___Fear/Anxiety
___Withdrawal	___Picked on/bullied by peers	___Anger Control
___Impulsive	___Difficulty following rules	___Excessive worry

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___Problems completing schoolwork	___Social fears	___Separation problems
___Bedwetting	___Headaches/stomachaches	___Odd beliefs/fantasizing
___Nightmares	___Frequent tantrums	___School refusal
___Perfectionism	___Hallucinations	___Lying
___Running away	___Skipping School	___Alcohol/Drug use
___Argumentative	___Defiant	___Trouble with the law
___Blames others for mistakes	___Stealing	___Being destructive
___Hurting others	___Short-tempered	___Easily annoyed

CURRENT HABITS

Please describe your child's current habits in each of the following areas:

Drinking: _____

Smoking: _____

Drug Use: _____

TV Use: _____

Internet Use: _____

Video Game Use: _____

Social Media Use: _____

Caffeine Intake: _____

Exercise: _____

Eating: _____

Sleeping: _____

Fun and Relaxation: _____

Chores and Responsibilities: _____

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RELATIONSHIPS

Please describe your child's relationships with each of the following people, if applicable:

Biological Mother: _____

Biological Father: _____

Step-parents: _____

Legal guardians: _____

Siblings: _____

Extended family: _____

Friends: _____

Romantic Partner(s): _____

Colleagues or Classmates: _____

Total number of close, supportive relationships: _____

STRESSFUL LIFE EVENTS

Please describe any significant or stressful life events that your child has been experiencing:

Recent move or change in school _____

Abuse/Neglect _____

Bullied or ignored by peers_____

Academic difficulties_____

Self-injury_____

Death or illness of a loved one or pet_____

Family conflict_____

Separation or divorce_____

Has your child ever been verbally abused? _____

Has your child ever been physically abused? _____

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Has your child ever been sexually abused? _____

Has your child ever witnessed domestic violence? If so, please specify. _____

_____

_____

How is your child disciplined? Please list each method and frequency of use: _____

_____

_____

CHILD'S DEVELOPMENTAL AND FAMILY HISTORY

Please check all that apply.

Pregnancy: Full-term_____ Premature_____ If premature, number of weeks_____

Mother used during pregnancy: Alcohol _____ Drugs _____ Nicotine _____

Delivery: Normal _____ Breech _____ Cesarean _____

Family History:

Chemical Use (now & past): No _____ Yes _____ Which parent(s) _____

Type: Alcohol _____ Marijuana _____ Other drugs_____

List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):

_____

_____

_____

_____

What are your child's strengths? _____

_____

_____

_____

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_____

Please tell us about your child's interests (sports, hobbies, talents, etc.) _____

_____

_____

_____

_____

What are your 2 most important goals for therapy?

1. _____

   _____

   _____

   _____

2. _____

   _____

   _____

   _____

Any additional comments or information that would be helpful to us?

_____

_____

_____

_____

_____

_____

_____

_____

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