Tyson D Bailey, PsyD

Child/Adolescent Information Sheet

This questionnaire is intended to help me get an understanding of your child's experiences, to assist in the treatment planning process. Please provide the following information and answer the questions below and bring it to your first session. Please feel free to leave any question blank that you would rather not answer in this format.

Child's Name: _____

Date:_____

Birth date: _____/_____/_____ Age: _____ Gender: _____

Address: _____

City, State: _____ Zip: _____

Parent/ Guardian Name(s):

_____

Home Phone: (____) May I leave a message? □Yes □No

Cell/Other Phone: (____) May I leave a message? □Yes □No

E-mail: _____ May I email you? □Yes □No

***Please note**: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Please write a brief description of the reasons you and seeking therapy or assessment for your child: _____

_____

_____

_____

_____

_____

_____

_____

School:_____ Phone:_____ Teacher:_____

Grade: _____

How does your child do in school academically?

_____

_____

_____

How does your child do in school behaviorally?

_____

_____

_____

Does your child have a learning or physical disability? __Y, __N, __Maybe. Specify:

_____

_____

Does your child have a mental health diagnosis? __Y, __N, Specify:

_____

_____

_____

_____

Does your family have specific spiritual beliefs? _____

_____

Medical History

During pregnancy, did mother use:

__ Cigarettes, __ Alcohol, __ Drugs, __ Experience Extreme Stress?

Specify frequency, amounts, and duration: _____

_____

_____

List any birth complications (Ex: Premature, jaundice, C-section, etc.)

_____

_____

List any Medical conditions or history (Ex: Surgeries, broken bones, allergies, etc.)

_____

_____

Has your child experienced any significant head injuries, concussions, or loss of consciousness?

Y N If Y, please specify frequency, amount, and duration:

_____

_____

_____

Does child use: __ Cigarettes, __ Alcohol, __ Drugs

Specify amount and frequency:

_____

Primary Care Physician: _____ Phone:_____ Last seen on: _____

Psychiatrist: _____ Phone:_____ Last seen on: _____

Current medications: (Include dosage and frequency): _____

_____

_____

Medication Allergies:

_____

Other Allergies:

_____

In the first two years, did your child experience:

__Separation from mother __Out of home care __Disruption in bonding

__Depression of mother __Abuse __Neglect __Chronic pain __Chronic Illness __Parental Stress

If yes, please specify:

_____

_____

_____

_____

Reached developmental milestones: __On time, __Early, __Late

How many times has the child moved homes?

_____

Family History

Biological Dad:_____ DOB:_____

Biological Mom:_____ DOB:_____

___ Married; ___ Separated; ___ Divorced

Siblings (1st to last):

Name: _____ Age:____

Name: _____ Age: ____

Name: _____ Age:____

Name: _____ Age: ____

Name: _____ Age:____

Custodial Adults (If not biological parents):

Dad: _____ DOB:_____

Mom: _____ DOB: _____

Date became caretaker: _____

People in household, if different from above:

_____

_____

Does father work outside of the home? __Y, __N; Occupation: _____

Hours:_____

Father's highest level of education:

_____

Does mother work outside of the home? __Y, __N; Occupation: _____

Hours:_____

Mother's highest level of education:

_____

If separated or divorced, visitation schedule:

_____

What is custody arrangement regarding physical and mental health care (if applicable):

_____

_____

Does either parent have legal issues?

_____

_____

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.):

_____

_____

_____

_____

Have children witnessed domestic violence? __Y, __N, Specify: _____

_____

_____

_____

_____

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

_____

_____

_____

Trauma History (Please use back of paper if more space is needed)

Has your child been verbally abused? __Y, __N, __Suspected. Specify:

_____

_____

Has your child been physically abused? __Y, __N, __Suspected. Specify:

_____

_____

Has your child been sexually abused? __Y, __N, __Suspected. Specify:

_____

_____

Other stressors or traumas?

_____

_____

How does your child/adolescent handle anger?

Has the child/adolescent experienced any significant loss? If yes, explain:

What do you view as your child/adolescent 's major strengths and positive traits?

What are your child/adolescent's hobbies?

What are your child/adolescent's responsibilities at home?

How well does your child/adolescent's handle these responsibilities?

Briefly describe your goals for your child/adolescent's therapy:

Please list any information you deem to be important for the therapist to know:

_____

_____

_____

Who shall I contact in case of emergency?

Name:_____

Contact Number (If different from above): _____