Belmont Psychological Services
A Psychology Corporation
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www.belmontpsych.com

Child and Adolescent Information Form

Please Print Clearly

Child's full Name _____ DOB _____ Age _____

Home Address _____
STREET CITY STATE ZIP

Home Phone _____ Mobile Phone _____ SSN ___ – ___ – ____

Pediatrician _____ Religion _____

Name of School _____ Present Grade or Highest Level Completed _____

Referred by: ☐ Self ☐ Physician, if so Who? _____ ☐ Other(specify) _____

Responsible Party Information

Please provide information about the person financially responsible for treatment

Responsible Party Name _____ SSN ___ – ___ – ____

DOB _____ Relationship to Patient _____ Email _____

Home Address _____
STREET CITY STATE ZIP

Home Phone _____ Mobile Phone _____ Work Phone _____

Occupation _____ Employer _____ Job Title _____

Employer Address _____
STREET CITY STATE ZIP

Significant Other (Second Parent / Spouse) Information

Name _____ SSN ___ – ___ – ____

DOB _____ Relationship to Patient _____ Email _____

Home Address _____
STREET CITY STATE ZIP

Home Phone _____ Mobile Phone _____ Work Phone _____

Occupation _____ Employer _____ Job Title _____

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Emergency Contact Information

Name _____ Phone _____ Relationship to Patient _____
Name _____ Phone _____ Relationship to Patient _____

Household Members:

Name	Age	Relationship to Child	Occupation / Grade

History

Please describe the primary symptoms for seeking therapy at this time:

_____

_____

When did the symptoms begin? _____

Has your child ever been treated for mental health problems in the past? ☐ Yes ☐ No
If yes, When? _____ Where / By Who? _____
Was it helpful? ☐ Yes ☐ No Explain _____

Any family history of psychiatric or mental health problems? ☐ Yes ☐ No
If yes, please explain _____

Has your child ever been hospitalized for any psychiatric reasons? ☐ Yes ☐ No
If yes, When? _____ Where? _____

Has your child had difficulty at school? ☐ Yes ☐ No
If yes, please explain _____

Please list any significant medical conditions _____
_____

Has your child ever been prescribed medication for psychiatric or emotional difficulties in the past? ☐ Yes ☐ No
If yes, please list all medications:

Medication	Dosage	When (e.g. 06/12-02/13)	Prescribed for

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Please list all **CURRENT** medications your child is taking here:

Medication	Dosage	Frequency	Prescribed for

Please check the following areas in which your child is having difficulty:

☐ Aggression
☐ Alcohol Use
☐ Anger
☐ Anxiety
☐ Assertiveness
☐ Being a Parent
☐ Bereavement / Grief
☐ Boredom
☐ Bowel Troubles
☐ Career Choices
☐ Children
☐ Chronic Pain
☐ Concentration
☐ Compulsions
☐ Dating Skills
☐ Depression
☐ Distractibility
☐ Divorce
☐ Drug Use
☐ Eating Problems
☐ Educational Problems
☐ Energy
☐ Family
☐ Fears
☐ Finances
☐ Friends
☐ Guilt
☐ Hallucinations
☐ Headaches
☐ Health Problems
☐ Health Worries
☐ Hyperactivity
☐ Intrusive Thoughts
☐ Impulsiveness
☐ Irritability
☐ Isolation
☐ Legal Matters
☐ Loneliness
☐ Making Decisions
☐ Marriage
☐ Memory
☐ My Thoughts
☐ Nervousness
☐ Nightmare
☐ Obsessions
☐ Occupational
☐ Panic
☐ Perfectionism
☐ Phobias
☐ Relationships
☐ Relaxation
☐ Sadness
☐ Self-Control
☐ Self-Esteem
☐ Sexual Problems
☐ Shame
☐ Shyness
☐ Sleeplessness
☐ Stress
☐ Suicidal Thoughts or Gestures
☐ Tearfulness
☐ Upsetting Memories
☐ Unhappiness
☐ Worry

What are your goals for treatment?

1. _____

2. _____

3. _____

_____ _____

Signature of Parent / Guardian **Date**

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