**Cognitive Therapy Orange County**

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 **Child/Adolescent Information Form**

Child/Adolescent Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthplace \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB / / Age \_\_\_\_\_\_

Phone ( )

Present Grade\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Religion \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: ☐ Self ☐ Physician ☐ School ☐ Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Information**

Mother’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home/Cell Phone\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long on present job \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length of time lived in this area \_\_\_\_\_\_\_\_\_\_\_\_\_\_

School grade completed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Married ☐ yes ☐ no ☐ no

Years married \_\_\_\_\_\_\_

Do you live with your spouse ☐ yes ☐ no ☐ no

If married previously; give dates \_\_\_\_\_\_\_\_\_\_\_\_

Birthplace \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Religion \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Military Service \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home/Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long on present job \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length of time lived in this area \_\_\_\_\_\_\_\_\_\_\_\_\_\_

School grade completed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Married ☐ yes ☐ no ☐ no

Years married \_\_\_\_\_\_\_\_

Do you live with your spouse ☐ yes ☐ no

If married previously; give dates \_\_\_\_\_\_\_\_\_\_\_\_\_

Birthplace \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Religion\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Military Service ☐ no

**Parental Custody** (if applicable) □ Joint □ full/legal, who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Household Members**

|  |  |  |  |
| --- | --- | --- | --- |
|  Name |  Age |  Relationship to Child |  Occupation/Grade |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Medical Professionals:**

**Pediatrician:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Psychiatrist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**History**

Describe the reasons that caused you to schedule an appointment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did this begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Did you have any concerns about your child’s early development? ☐ yes ☐ no

 ☐ feeding ☐ sleeping ☐ talking ☐ walking ☐ toilet training ☐ other

Please briefly explain any items checked \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was your child: ☐ irritable ☐ good natured ☐ fussy ☐ difficult to comfort ☐ easy to comfort

Has your child had any significant medical problems? ☐ yes ☐ no

If yes please list:

|  |  |  |  |
| --- | --- | --- | --- |
|  Medical Problem |  Date |  On-going |  Resolved |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Has your child ever had psychotherapy or counseling before? ☐ yes ☐ no

If yes, When: Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was it helpful? ☐ yes ☐ no

Has your child ever received any type of psychological or educational testing?

If yes, When: Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever had medication prescribed for psychiatric or emotional difficulties? ☐ yes ☐ no

If yes, please list all medications:

|  |  |  |  |
| --- | --- | --- | --- |
| Medication |  Dosage |  When (e.g., 6/01-2/02) |  Prescribed for |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

What medications is your child currently taking?

|  |  |  |  |
| --- | --- | --- | --- |
|  Medication |  Dosage |  Frequency |  Prescribed for |
|  |  |  |  |
|  |  |  |  |

Has your child had difficulty at school? ☐ yes ☐ no

If yes, please briefly explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Extra-curricular interests: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hours per week for extra-curricular interests: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Please check (☒)the following areas in which your child is having difficulty:**

|  |  |  |  |
| --- | --- | --- | --- |
|  ☐ aggressive behavior ☐ alcohol use ☐ anger ☐ anxiety ☐ assertiveness ☐ boredom ☐ bowel troubles ☐ chronic pain ☐ concentration ☐ depression ☐ divorce ☐ drug use ☐ eating problems ☐ education ☐ low/high energy | ☐ excessive screen time☐ family☐ fears☐ fire setting☐ friends☐ grief☐ guilt☐ headaches☐ health worries ☐ health problems☐ hyperactivity☐ impulsiveness☐ inattention☐ internet use☐ irritability | ☐ isolation☐ loneliness☐ lying☐ making decisions☐ memory☐ my thoughts☐ nervousness☐ nightmare☐ opposition☐ panic☐ perfectionism☐ relationships☐ relaxation☐ self-control☐ self-esteem | ☐ seeing/hearing things not seen/heard by others ☐ shyness☐ sleep☐ stealing☐ stress☐ sudden changes of mood☐ suicidal thoughts☐ toilet training☐ upsetting memories☐ unhappiness☐ video gaming☐ worry☐ other: ­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ☐ seeing/hearing things not seen/heard by others ☐ shyness☐ sleep☐ stealing☐ stress☐ sudden changes of mood☐ suicidal thoughts☐ toilet training☐ upsetting memories☐ unhappiness☐ video gaming☐ worry☐ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*Signature of parent/guardian Date*