480.331.5002 www.excelsocialservices.com

Child/Adolescent Demographic Information

Date___________________

Child Name: ___________________________________ DOB: ___________ Age: ________

Child Primary Residence: ____________________________ City: ___________ Zip: _______

Caregiver(s) at this address: ____

We can send billing/treatment information to this address? ☐Yes ☐No

Child Second Residence ___________________________________ City: ___________ Zip: _______

Caregiver(s) at this address: ____

We can send billing/treatment information to this address? ☐Yes ☐No

Relationship Status of Child's Parents: ☐Married ☐Divorced ☐Separated ☐Widowed ☐Other

If divorced, what is the custody agreement? Custodian Parent: ☐Mother ☐Father

Joint Physical Custody: ☐50/50 ☐NON 50/50: ☐Mother ☐Father

Sole Physical Custody: Physical custodial parent: ☐Mother ☐Father

Non-Legal/Physical Custodian Parent's Visitation Rights:

____

____

Mother: ________________________________ Occupation: _______________________

Employer: _______________________________ Home phone: ________________ Cell #: __________

Father: _________________________________ Occupation: _______________________

Employer: _______________________________ Home phone: ________________ Cell #: __________

Referred by: ☐Physician ☐Friend ☐Google Ad ☐Website ☐Other ______________

I give permission to receive messages via:

☐Email ______________________________________

☐Text________________________ ☐Phone ______________________________________

Parent/Legal Guardian Signature: __________________________________ Date: __________

Parent/Legal Guardian Signature: __________________________________ Date: __________

Parent/Guardian Questionnaire
Each parent should complete their own questionnaire

Relationship to child: ______________________

My child's strengths are:

____
____
____
____

The 3 things that concern me the MOST are:

1. ____

2. ____

3. ____

What effect have these difficulties had on your child and your family?

____

____

____

What is the most challenging part of your relationship with your child?

____

____

I discipline my child in the following ways:

____

____

I want to improve my relationship with my child in the following ways:

____

____

The things I enjoy most about my relationship with my child are:

____

____

The 3 GOALS that I have for my child's therapy are:

1. ____

2. ____

3. ____

I will know things are better when:

1. ____

2.____

3.____

Parent/Guardian signature: ____________________________

Date________________________

Therapist's Notes:

Discussion of Goals and Methods:

Child Name: ______________________________ DOB: ________________ Age: _________

Person completing form: ____

Briefly describe the main reason you are seeking help for your child:

____

____

____

Please list all those living in your home besides the child. This includes spouse, siblings, partner, friends, and relatives:			
Name	Age	Gender	Relationship to Child
		☐M ☐F	
		☐M ☐F	
		☐M ☐F	
		☐M ☐F	
		☐M ☐F	

Separation/Divorce:		
Are parents separated or divorced?	☐Yes ☐No	If yes, for how long? ________
If parents are separated/divorced, does non-custodia parent share legal custody?	☐Yes ☐No	
Are both parents aware that this child will be receiving counseling?	☐Yes ☐No	
Does child have contact with both parents	☐Yes ☐No	How often? _____________

Counseling History:		
Has your child previously received counseling?	☐Yes ☐No	If yes, when and for what? ________________________________ ________________________________
Do you think that it was a positive experience for your child?	☐Yes ☐No	
Was it a positive experience for both parents	☐Yes ☐No	
Has your child received medication for behavior or moods?	☐Yes ☐No	If yes, what was the outcome? ________________________________

Please complete the following questions:

How well does your child fall asleep, stay asleep and wake up from naps and in the morning?
____
How does your child respond to separate?
____
What is your child's favorite things to do?
____
Please describe a typical day in the life of your child:
____
What is the most important thing that I can do for you today?
____

Medical History:		
Pediatric office:	Doctor:	
Address:	Phone:	
Does your child have any current/past medical/physical concern?	☐Yes ☐No	If yes, please describe: ______________
Has your child had any of the following? If yes, please explain:		
Head injuries?	☐Yes ☐No	If yes, did your child lose consciousness? ☐Yes ☐No
Hospitalizations?	☐Yes ☐No	______________
Surgeries?	☐Yes ☐No	______________
Medical procedures?	☐Yes ☐No	______________
Seizures? Serious illness	☐Yes ☐No	______________

☐ Hearing difficulties. ☐ Eye/vision problems ☐ asthma		
☐ Sensory problems (i.e. doesn't want to touch certain textures; bothered by bright lights)		
☐ Fine motor problems (handwriting, cutting, using fingers)		
☐ Gross motor problems (clumsy, poor balance, trouble running)		
☐ Allergies (food, pet, etc.) ☐ Yes ☐ No If yes, what? ___________________________		

Current Medications: please add additional information on back if needed:				
Name of Medication	Dose/frequency	Reason	How long prescribed	Prescribing Doctor

Prenatal/Birth History:	
Did mother receive prenatal care?	☐ Yes ☐ No
Were there any complications during: Pregnancy. ……. Labor…….. Delivery……….	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Was child born premature or full-term? ☐ Vaginal or ☐ Caesarian?	☐ Yes ☐ No
Child's weight at birth? ______________________	
Was there an extended hospital stay for mother/child after delivery?	☐ Yes ☐ No
Did child spend any time in the NICU?	☐ Yes ☐ No
Alcohol or drug use during pregnancy?	☐ Yes ☐ No
Use of medication during pregnancy?	☐ Yes ☐ No
Did mother have post-partum depression?	☐ Yes ☐ No

Please check any items below that your child experienced as an infant or toddler:	
☐ Exposure to lead	☐ Poor attachment to parents/caregivers
☐ Repetitive movements	☐ Slow response when called by name
☐ Walking/gross motor delay	☐ Avoidance of eye contact
☐ Difficult to comfort	☐ Sleeping difficulties
☐ Speech/Language delay	☐ Problems eating
☐ Hand coordination/fine motor delay	☐ Separation from parents
☐ Overly social/friendly	☐ Not wanting touch
☐ Eating non-foods	☐ Loss of previous abilities

☐Clingy	☐Other

Developmental Milestones: Please note any delays or concerns with following milestones:	
Sitting:	Crawling:
Standing:	Walking:
First word:	Two-word sentences
Toilet trained	Imitates others

Education:		
School:	Grade:	Teacher:
Has your child attended other schools?	☐Yes ☐No	How many?
What prompted the change? ____		
Overall, how is your child academic progress? ☐Excellent ☐good fair ☐ Poor ☐struggling		
Does your child receive any special services? ☐Tutoring (in school/private) ☐occupational/speech/physical therapy ☐IEP Others: _________________________		
Have you ever been called to pick your child up at school due to misbehavior? ☐Yes ☐No For what: ____		
Has your child ever had detention, been suspended or asked to leave a school? ☐Yes ☐No How long ago: ____		
Does your child ever report not liking school or teachers? ☐Yes ☐No		

Family Mental Health History – Family history is important to understanding your child's behavior and treatment. Please indicate below if anyone in the family has experienced the following:		
Has anyone experienced?	Mother's side	Father's side
Anxiety		
Depression		
Bipolar disorder		

Learning disorder (ADHD, dyslexia)		
Drug abuse		
Alcohol abuse		
Panic Attacks		
Collecting useless items		
Schizophrenia		
Suicide attempts		
Completed suicide		
Violent temper		
Abuse (physical/emotional/verbal/sexual		
Hallucinations or delusions		
Strange behavior or thinking		
Other:		

Behavior Checklist: Pleaser check items that describe your child's behavior for the past year:	
☐ Academic/homework problems	☐ Being bullied or bullying
☐ Not interested in things	☐ Repetitive habits
☐ Angry mood/rages	☐ Bossiness
☐ Paying attention, focusing difficulties	☐ Unusual behavior
☐ Anxiety	☐ Confused thinking
☐ Perfectionism	☐ Self-injury
☐ Arguing	☐ Crying frequently
☐ Playing with fire	☐ Separation anxiety
☐ Defiant (to parents or other adults	☐ Hair pulling
☐ Sexualized behavior that seems inappropriate	☐ Eating issues (too much, too little)
☐ Destroys things	☐ Stealing
☐ Shyness (excessive)	☐ Strong feelings of guilt or shame
☐ Disorganized, loses things	☐ Easily frustrated
☐ Sleeping, waking difficulties	☐ Emotional outbursts
☐ Doesn't want to try new things	☐ Suicide attempts
☐ Somatic complaints (headaches/stomachaches)	☐ Fears
☐ Suicidal thoughts (says wants to die)	☐ Grief/loss
☐ Forgetfulness	☐ Threats or comments about hurting self
☐ Talking back	☐ Frequent conflict
☐ Threats or comments about hurting others	☐ Tantrums
☐ Hard to make/keep friends	☐ Hears or sees things other do not
☐ Too concerned with neatness	☐ Toileting

☐ Hits others	☐ Strong reactions to textures, light, sound
☐ Transitions are difficult	☐ Hyper: trouble sitting still
☐ Hurts animals	☐ Unhappy, sad or depressed
☐ Wetting/soiling pants or bed	☐ Impulsive
☐ Lack of confidence	☐ Unusual thoughts
☐ Learning and remembering problem	☐ Irritable
☐ Mood quickly goes up and down	☐ Worries a lot
☐ Withdrawn, not sociable	☐ yelling
☐ Nightmares/Night terrors	☐ Won’t speak outside the house

Therapist Note:

Therapist Name: ___________________________

Therapist Signature: _______________________________ Date: _______________________