**Katrina Zeljak, LMFT #99775**

**Child/Adolescent Information Form**

**Client**: _____ Date of Birth _____

**Mother/Partner**

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail _____ Marital Status_____

Preferred Contact _____ Occupation/Employer: _____

**Father/Partner** _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____Cell Phone _____

E-mail _____Marital Status _____

Preferred Contact _____ Occupation _____Employer _____

Others living at home

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name of Closest Friend/Relative _____ Phone _____

Address _____

Presenting Concern: _____

History of Concern:_____

Referred By: _____

Previous Psychotherapy? Yes____No _____ Dates _____

Concerns During Pregnancy/delivery/infancy? _____

How would you describe your child's first year of life?_____

Pediatrician: _____

Last medical exam date _____ Findings _____

Current medications (including herbal supplements)? _____ Type/Dosage _____

Previous Counseling? _____

Exposure to second hand smoke, alcohol, substance use? _____

Concerns During/Regarding: _____ Exercise _____ Sleep/Nighttime

_____ Potty Training _____ Kindergarten _____ Walking _____ Separation

_____ Pre-School _____ Crawling _____ Eating _____ Speaking

School Concerns_____

SST Meeting Held/504/IEP Plans:_____

Current Social Concerns: _____

Current Behavior or Family Concerns: _____

What are the goals that you would like to achieve by participating in therapy?

_____

_____

**Select any of the following that may apply:**

| | | | | | |
|---|---|---|---|---|---|
| | Headache | | Inferiority Feelings | | Shy With People |
| | Dizziness | | Bingeing/Purging | | Difficult to Please/Easily Bored |
| | No Appetite/Overeating | | Depressed | | Perfectionism |
| | Tired/Sleepy Feelings | | Suicidal Ideas | | Indecisive |
| | Unable to Relax/Nervous | | Hallucinations | | Disorganized/Losing Items |
| | Insomnia | | Hopelessness/Crying | | Difficulty Making/Keeping Friends |
| | Nightmares | | Separation Anxiety | | Bed Wetting/Soiling |
| | Picking/Hair Pulling | | Poor Impulse Control | | Poor School Behavior |
| | Feel Panicky | | Attention Issues/Distracted | | Frequent Temper Tantrums |
| | Fears and Phobias | | Sensory Sensitivity | | Frequent Bathroom Accidents |
| | Feel Tense/Irritable | | Allergy/Asthma | | Concerns with Masturbation |
| | Cutting/Self-Harm | | Gender Concerns | | Fire Setting |
| | Obsessions | | Substance Use | | Truancy/Running Away |
| | Excessive Worry | | Sexuality Concerns | | Cruelty to Animals |

If you have any additional information, or if you require more space to answer any of the questions from above, please use the back of this form.

*By signing below, I hereby confirm that the information furnished is true and correct.*

_____

Legal Guardian Signature Date:

On behalf of (minor child): _____

Relationship to Child: _____