Acme Counseling and Consulting Services
Valerie Peckham, LCP

Child/Adolescent Admission Questionnaire

Parents should complete these forms and bring them to the first session. Please answer the questions below truthfully to your best knowledge. Please note: information you provide here is protected as confidential information.

Child's Name: ____

Parent/Guardian Names:____

Birth Date: ______ /______ /______ Age: ________ Gender: □ Male □ Female

School: ____ Grade ________________________

Home Address: ____
(Street and Number) (City, State) (Zip)

Additional Address:____
(Street and Number) (City, State) (Zip)

Home Phone(s): ____________________________________ May we leave a message? □ Yes □ No
____________________________________ May we leave a message? □ Yes □ No
Cell/Other Phone(s): ________________________________ May we leave a message? □ Yes □ No
________________________________ May we leave a message? □ Yes □ No
Other Phone: ______________________________________ May we leave a message? □ Yes □ No

E-mail: ____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Would you like to receive appointment reminders via text _____ and/or email _____ ? Initial for Consent ________

Religious Affiliation: ________________________________ Is the child employed □ No □ Yes_______________

Please list any long periods of time your child/teen has been out of school for any reason including major illness, home-schooling, expulsion, etc. ____
____

Please list all individuals the Child/Teen lives with (including extended family or house guests in all households):

Name	Sex (circle)	Age	Relationship
________________________________	Male Female	___	______________________________________
________________________________	Male Female	___	______________________________________
________________________________	Male Female	___	______________________________________
________________________________	Male Female	___	______________________________________
________________________________	Male Female	___	______________________________________
________________________________	Male Female	___	______________________________________
________________________________	Male Female	___	______________________________________
________________________________	Male Female	___	______________________________________
________________________________	Male Female	___	______________________________________

If child/teen is not living with one or both birth parents, what is the reason? ______________________________
____
____

Is your child/teen currently under a physician's care? □ No □ Yes (Complete section below)
If yes, name of physician and reason: ____
List any current medications and dosage: ____
____
____

Has your child/teen received prior counseling or related services? □ No □ Yes (Complete section below)

Name of therapist: ___________________________ Where: _______________________________________
Length of treatment: _____________mos./years How long ago? __________ mos./years ago
Problem(s) treated: ____
Outcome: (circle one):

1 2 3 4 5 6 7 8 9 10
Much worse Stayed the same Much better

Name of therapist: ___________________________ Where: _______________________________________
Length of treatment: _____________mos./ years How long ago? __________ mos./years ago
Problem(s) treated: ____
Outcome: (circle one):

1 2 3 4 5 6 7 8 9 10
Much worse Stayed the same Much better

Please check all of the reasons listed below that lead you to seek assistance/treatment for your child, marking the most important with a *:

____ Sadness, Depression, or Grief
____ Anxiety, Fears, or Phobias
____ Worry about drinking or drug use
____ Communication problems
____ Child arguing with parent(s)
____ Child arguing with brothers/sisters
____ Trouble concentrating
____ Sexual orientation questions
____ Problematic or too much anger
____ Feel alone/trouble making friends
____ Trouble controlling impulses
____ Difficulty with loss or death
____ Trouble staying organized
____ Refusing to attend school
____ Other: ___________________________
____ Other: ___________________________
____ Worry that he/she is suicidal or will hurt him/herself
____ Withdrawn
____ Child's behavior is out of control
____ Abuse (physical/sexual/emotional/verbal)
____ Trauma other than abuse (natural disaster, accident, crime witness, etc.)
____ Getting in trouble at school
____ Learning problems
____ Trouble concentrating
____ Trouble following directions
____ Clingy/tearful
____ Verbally or physically aggressive
____ Trouble getting child to bed at night or sleeping
____ Concerns about appetite or eating habits
____ Other: ___________________________
____ Other: ___________________________

When did your concerns begin? ____

How often does the issue happen? ____

How concerned are you? ____

How does it affect your child's functioning?
____ My child can do all the things he/she needs and wants to do
____ My child struggles a bit but is able to do all he/she needs and wants to do
____ My child can only do some of the things he/she needs and wants to do
____ My child can barely do the things he/she needs to do
____ My child is unable to take care of him/herself

Please describe any family history of mental/emotional concerns, illnesses, or diagnoses (eg. Depression, anxiety, schizophrenia, etc. in ANY family member including parents and siblings)

___

___

___

Please describe any difficulties/complications/concerns with the pregnancy, birth, or early childhood of your child. Have there ever been any developmental concerns for your child?

___

___

___

Please describe any major medical events your child has experienced (surgery, major illness/injury, head injury, etc.)

___

___

___

Please describe any family history of violence or abuse (including parents and siblings).

___

___

___

Please describe any family history of alcohol or substance abuse or dependence (including parents and siblings).

___

___

___

Please describe any legal/arrest history for family or child/teen (including parents and siblings).

___

___

___

Please describe any academic or school performance concerns you have for your child.

___

___

___

Please describe any social or peer concerns you have for your child.

___

___

___

Please describe any other concerns or anything else you want the therapist/counselor to know.

___

___

___

___

Who referred you/your child to therapy? ___

Emergency Contact: ___ Relationship: ___

Phone numbers: Home: ___ Work: ___ Cell: ___

Please sign below to confirm accuracy of the above information.

Parent/Guardian Signature: ___ Date: ___

Relationship: ___