**Cognitive Therapy Orange County**

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

151 Kalmus Drive, Suite B/220 • Costa Mesa, CA 92626 • (949) 675-0545 • fax (714) 437 1687 • www.cognitivetherapyoc.com

**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*