DEBRA K. KRESCH, LCSW, LMFT, BCD
Individual Psychotherapy • Marriage & Family Counseling • 760 436-6892

CHILD/ADOLESCENT PERSONAL DATA FORM: All information is held in strict confidence. Your open and honest responses help to facilitate the therapeutic process. Thanks!

Child's Name:____ Date:________________________

Name of parent(s)/guardian: ____

Mother's Occupation: ____________________________ Father's Occupation: ________________________

Parent(s) Marital Status: ❑ Never Married ❑ Separated ❑ Domestic Partnership ❑ Divorced
❑ Married ❑ Widowed

Child's Birth date:___________________ Age:_______ Birth place:_________________ ❑ Male ❑ Female

School: _______________________________ Grade:_______________________________

Religious and/or cultural identification (if any):____

Address:____
City:____ State:____________ Zip:____________________
Home #:__________________ Parent's cell #:_____________________ Child's Cell #:___________________

Where can I leave a message? ❑ home ❑ Parent's cell ❑ Child's cell Fax # _______________________

Parent e-mail address: _______________________________ May billing statements be e-mailed ?_______

Referred by:____________________________________ Physician:__________________________________

Do you give permission to coordinate care with child's physician? _________________________________

Emergency Contact: Name _________________________Phone _________________ Relationship_________

Presenting Concern:

____
____
____
____
____

History of Present Concern:

____
____
____
____
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Child's Emotional Functioning and Symptoms: (Circle whatever applies, fill in the blanks)

Depression: sad/irritable mood, tearfulness, helplessness, hopelessness, low interest in activities, guilt feelings, low self-esteem, fatigue, insomnia/hypersomnia, low/high appetite, gain/loss weight, bingeing/purging behavior, cutting, suicidal ideation. Other:______________________________

Anxiety: anxious/nervous mood, nightmares, night terrors, sleep walking, constant worry, obsessions, compulsions, ruminations, nail biting, picks at self, hair pulling, somatic complaints, fears/phobias, tics, panic attacks, separation anxiety, avoidance behaviors. Other:___________________________

Developmental/Social/Academic History: (Circle whatever applies, fill in the blanks)
Pregnancy/delivery problems:____
Developmental concerns:____
Number of siblings: ______ Birth order: #____ Age when parents divorced /separated (if applicable)___
Relationship with mother _______ father ________ Relationship with siblings______________________
History of abuse/trauma:____
Peer relationships:____
Academic performance:__________________Grade repeated:_______ Learning Disability:____________
Special Education:__________________School behavior:____

Conduct/behavior problems: Fire setting, running away, lying, stealing, truancy, cruelty to animals/people, defiance, disrespect of property/people, fighting, lack of remorse or guilt, oppositional behavior/attitude, self-mutilation.

Attention problems: lack of sustained attention, distractibility, loses things, forgetful, disorganized, fidgety, poor listening, hyperactive, impulsive, interrupts others, difficulty in waiting turn, impatient, wants to be first.

Strenghts:____
____
____

Child's/Adolescent's Medical/Psychiatric History:
Significant illness/injury/surgery/allergies:____
____
____
History of seizures/loss of consciousness:____
Past psychiatric hospitalization/counseling:____
History of suicidal ideation/gestures:____
Alcohol/Substance abuse/treatment:____

Please list below any medications/vitamins that your child is taking:

Medication/Vitamins	Dosage	When started	Reason	Prescribing M.D.

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FAMILY DATA:

Family Psychiatric History (i.e. bipolar disorder, depressive disorder, ADHD, OCD, anxiety disorder, eating disorder, schizophrenia, dementia, suicide or attempts - include child, parents, siblings, grandparents)

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____
____
____
____
____

Family alcohol/substance abuse/treatment:______________________________

Significant Family Events (i.e. divorces, deaths, losses, traumas, domestic violence - include dates)

____
____
____
____
____
____

Current family stressors (i.e. relationship/family, loss, school, job, unemployment, housing, finances, health, legal)

____
____
____
____
____
____

Family (include immediate family and people who live in your household)

Relationship	Name	Age	Occupation	Residence

Pets:____
____

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Authorization for Counseling of Minors

I/We___________________________________, the parent(s)/legal guardian(s) of____________________________ give our permission for him/her to participate in individual counseling with Debra K. Kresch. Parents are the holders of confidentiality privilege. It is my policy to inform parents of their child's attendance and progress. Specific details are not shared in order to maintain therapeutic boundaries.

Signed: ______________________________ Date:_______________

Address: ______________________________

____

Home # _______________ Work #_______________ Cell #________________

Signed: ______________________________ Date:_______________

Address: ______________________________

____

Home # _______________ Work #_______________ Cell #________________

Witness: ______________________________ Date:_______________