# SAMARITAN COUNSELING CENTER

1803 OREGON PIKE
LANCASTER, PA 17601
717-560-9969

APPOINTMENT DATE:____________
APPOINTMENT TIME:____________
THERAPIST:____________________

LOCATION: □ 1803 OREGON PK, LANCASTER □ 810 DONEGAL SPRINGS RD, MOUNT JOY

## CHILD AND ADOLESCENT REPORT FORM

This questionnaire asks you to respond to a series of questions about your child and your family. Please complete these forms as best you can. We will have the opportunity to discuss them in detail at the time of your child's appointment.

Today's date:____________________

Child's Name | Child's Date of Birth | Age | Grade | Child's Soc. Sec. #

Person Completing Form | Your Relationship to Child

Mother's Name | Date of Birth | Work Phone | Home Phone | Cell Phone

Address | City | State | Zip

Father's Name | Date of Birth | Work Phone | Home Phone | Cell Phone

Address | City | State | Zip

Is this your biological, adopted, step, foster, other______________________child?

Are the child's legal parents married? ❐ No ❐ Yes

Is there a legal custody agreement? ❐ No ❐ Yes – Please provide at first session.
If yes:
In whose physical custody is this child? ❐ Mother ❐ Father ❐ Both ❐ Other
In whose legal custody is this child? ❐ Mother ❐ Father ❐ Both ❐ Other
(Note: consent must be obtained from all persons with legal custody prior to meeting with your child)

If other, Name | Work Phone | Home Phone | Cell Phone

Address | City | State | Zip

Health Insurance Company:________________________________________

ID Number:______________________________Group Number:____________________

Name of and Child's Relationship to the Policy Holder:______________________________

Date of Birth of the Policy Holder:________________Employer of the Policy Holder:____________________

Who Will Be Responsible For Payment?______________________________

Who Referred You To Samaritan Center?______________________________

What are your concerns about this child? What are the difficulties/problems that cause you to seek help at this time?____________

______________________________________________________________

______________________________________________________________

______________________________________________________________

## CHILD’S DEVELOPMENTAL HISTORY

**Pregnancy**

Mother’s age at the time of pregnancy with this child________ Length of pregnancy in months (or weeks) if known_______________

Were any medications used during pregnancy? ❒ No ❒ Yes; please specify.___________________________________

Did the mother smoke cigarettes during this pregnancy? ❒ No ❒ Yes; please specify average number per day.____________

Did the mother drink alcohol during this pregnancy? ❒ No ❒ Yes; please specify what type of alcohol and how much was consumed per day________________________________________________________________________________________

Did the mother use any type of drugs during this pregnancy? ❒ No ❒ Yes; please specify what type of drugs and amount used per day_________________________________________________________________________________________________

Pregnancy complications (check all those that apply):
❒ bleeding ❒ high blood pressure ❒ toxemia
❒ infections ❒ diabetes ❒ other, please explain:________________________

**Delivery**

Type of labor: ❒ spontaneous ❒ induced due to____________________________________________________________

Type of birth delivery: ❒ normal ❒ breech ❒ Cesarean section

Duration of labor:________hours

Were there any problems with labor and/or delivery? ❒ No ❒ Yes (please explain):_________________________________

**Perinatal History**

Baby’s weight at birth:________pounds___________ounces Baby’s length at birth:________inches

Any problems or comments regarding this child when he/she was a newborn? ❒ No ❒ Yes; please specify.__________________

**Infancy and Early Childhood**

Colicky ❒ No ❒ Yes, please specify__________________________________________

Feeding problems ❒ No ❒ Yes, please specify__________________________________________

Sleeping problems ❒ No ❒ Yes, please specify__________________________________________

Restless ❒ No ❒ Yes, please specify__________________________________________

Active ❒ No ❒ Yes, please specify__________________________________________

Did not enjoy cuddling ❒ No ❒ Yes, please specify__________________________________________

Excessive fearfulness ❒ No ❒ Yes, please specify__________________________________________

Excessive shyness ❒ No ❒ Yes, please specify__________________________________________

Strong reluctance to separate from mother ❒ No ❒ Yes, please specify__________________________________________

Headbanging ❒ No ❒ Yes, please specify__________________________________________

Accident prone ❒ No ❒ Yes, please specify__________________________________________

Uncoordinated ❒ No ❒ Yes, please specify__________________________________________

Are there other problems or comments regarding this child’s infancy and early childhood development? If so, please explain:_________

Child’s approximate age when she/he began: walking________months

talking (single words) _________months

talking (short sentences--2+ words) ________years

toilet training: daytime________years nighttime________years

Does this child have wetting accidents in bed currently? (day/night?) ❒ No ❒ Yes

Does this child have soiling accidents currently? (day/night) ❒ No ❒ Yes

Did this child previously have a problem with wetting or soiling? (day/night?) ❒ No ❒ Yes; please explain.__________

______________________________________________________________________________

Overall, do you feel this child developed at a ❒ slower rate ❒ average rate ❒ rapid rate

Please explain:_______________________________________________________________

______________________________________________________________________________

Any special health considerations? Please explain. _____________________________________

ADDITIONAL INFORMATION

______________________________________________________________________________

Child's Pediatrician Phone

______________________________________________________________________________

Address City State Zip

Have you notified the child's physician of your appointment here? ❒ No ❒ Yes

Have you discussed this child's problems with the physician? ❒ No ❒ Yes

Current health: ❒ poor ❒ fair ❒ good ❒ excellent

Child's present height________feet________inches Child's present weight________pounds

Is this child in any way physically ill at this time? ❒ No ❒ Yes; please explain __________________

______________________________________________________________________________

Does this child have any medication allergies? ❒ No ❒ Yes; specify medication(s) and reaction(s):__________

______________________________________________________________________________

Does this child have any other allergies? ❒ No ❒ Yes; specify type(s) and reaction(s):__________

______________________________________________________________________________

Is this child taking any type of medication at this time? ❒ No ❒ Yes; please list below :

| Name of Medication | Dosage | Duration | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Has this child experienced any serious traumatic events? ❒ No ❒ Yes. If so, please explain:__________

______________________________________________________________________________

Has this child ever been physically abused? ❒ No ❒ Yes. If so, please explain:__________

______________________________________________________________________________

Has this child ever been sexually abused? ❒ No ❒ Yes. If so, please explain:__________

______________________________________________________________________________

Is this child *currently* involved in any type of professional mental health treatment? ❒ No ❒ Yes

Has this child ever been involved in any type of professional mental health treatment? ❒ No ❒ Yes

Name of therapist | Age of this child at the time of treatment | Duration | Purpose of therapy

______________________________________________________________________

______________________________________________________________________

Has this child ever been taken to the Emergency Room? ❒ No ❒ Yes; at age_________Reason ______________________

______________________________________________________________________

Has this child undergone any type of surgery? ❒ No ❒ Yes; at age_________Type of Surgery________________

______________________________________________________________________

Was this child hospitalized for any other type of illness thus far not covered? ❒ No ❒ Yes; at age ________Reason____________

______________________________________________________________________

Has this child suffered any type of head injuries? ❒ No ❒ Yes; at age __________With loss of consciousness?______________

Has this child experienced any seizures? ❒ No ❒ Yes; at age__________Cause of seizures______________________

Has this child suffered from ear infections? ❒ No ❒ Yes; specify the types of medical treatment this child has received for his/her infections (e.g., antibiotics, antihistamines, tubes).____________________________________

Total number of ear infections (approximately)_______ Longest duration of any ear infection_________________________________

Do you see this child as:

| | | | | | |
|---|---|---|---|---|---|
| hyperactive | ❒ No | ❒ Yes | acting without thinking | ❒ No | ❒ Yes |
| having problems with attention and concentration? | ❒ No | ❒ Yes | engaging in reckless behavior | ❒ No | ❒ Yes |
| forgetful | ❒ No | ❒ Yes | disorganized | ❒ No | ❒ Yes |
| frequently losing things | ❒ No | ❒ Yes | | | |

Is this child, or was this child, associated with a spiritual/religious community, group or place of worship?_________________________

What is the name of the organization?____________________________________________________________

## CHILD'S EDUCATIONAL PLACEMENT

______________________________________________________________________

Name of School | School District | Grade

______________________________________________________________________

Type of Classroom Placement (e.g., regular, ED, LD, Resource Room, etc.)

Generally, what are this child's grades? ❒ A/B ❒ B/C ❒ C/D ❒ D/F

Did this child repeat any grades? ❒ No ❒ Yes; grade(s)_________________________________________

Did this child fail any subjects? ❒ No ❒ Yes; which subject(s)_________________________________________

Does this child currently receive any special education services? ❒ No ❒ Yes; type_________________________________
(e.g., self-contained class, resource room, reading lab)
Hours/day or week________________________

## MOTHER'S FAMILY HISTORY

Name:____________________________________________Birth Date:___________________________Age:__________________

Birth Place:_________________________________Religion/Church:__________________________________________________

Highest Grade Completed:___________________________________________Highest Degree:____________________________

Have you experienced difficulties with learning? ❒ No ❒ Yes; please describe____________________________

______________________________________________________________________

Any mental health problems for which you have received treatment? ❒ No ❒ Yes; please describe the problem and the treatment received.__________________________________________________________________

Any medical problems? ❒ No ❒ Yes If yes, please specify.________________________________________

Do you smoke cigarettes? ❒ No ❒ Yes; cigarettes/day________________________________________

Do you currently drink alcohol? ❒ No ❒ Yes; type of alcohol________________________________________

Number of drinks/day/week/month______________________________

Do you currently use any type of drugs? ❒ No ❒ Yes; type of drugs________________________________________

Frequency________________________________________

Occupation____________________________________Current Place of Employment________________________________

During which years of your child's life have you worked?________________________________________________

Current marital status:

| | | | | |
|---|---|---|---|---|
| Married | _______years | | Separated | _______years |
| Partner | _______years | | Divorced | _______years |
| Single | _______years | | Widowed | _______years |

Other (please explain):________________________________________________________________

Marital History: How many times been married (including current)?______________________________________

## FATHER'S FAMILY HISTORY

Name:_________________________________________Birth Date:___________________________Age:________________

Birth Place:________________________________Religion/Church:________________________________________________

Highest Grade Completed:________________________________________Highest Degree:___________________________

Have you experienced difficulties with learning? ❒ No ❒ Yes; please describe________________________________

____________________________________________________________________________________________________

Any mental health problems for which you have received treatment? ❒ No ❒ Yes; please describe the problem and the treatment received.________________________________________________________________________________

Any medical problems? ❒ No ❒ Yes; please specify.________________________________________

Do you smoke cigarettes? ❒ No ❒ Yes; cigarettes/day________________________________________

Do you currently drink alcohol? ❒ No ❒ Yes; type of alcohol________________________________________

Number of drinks/day/week/month______________________________

Do you currently use any type of drugs? ❒ No ❒ Yes; type of drugs________________________________________

Frequency________________________________________

Occupation________________________________ Current Place of Employment________________________________

During which years of your child's life have you worked?________________________________________________

Current marital status:

| | | | | |
|---|---|---|---|---|
| Married | _______years | | Separated | _______years |
| Partner | _______years | | Divorced | _______years |
| Single | _______years | | Widowed | _______years |

Other (please explain):________________________________________________________________

Marital History: How many times been married (including current)?______________________________________

## CHILD/FAMILY MEDICAL HISTORY

Has **your child** or anyone in his/her **family of origin** ever had the following? (For family, list the child's relationship to the person)

| | **Child?** | | **Family?** | | **Relationship** |
|---|---|---|---|---|---|
| ADHD | ☐ Yes | ☐ No | ☐ Yes | ☐ No | ________________ |
| Asthma | ☐ Yes | ☐ No | ☐ Yes | ☐ No | ________________ |
| Cancer | ☐ Yes | ☐ No | ☐ Yes | ☐ No | ________________ |
| Type? | ________________ | | ________________ | | |
| Cardiac Disease | ☐ Yes | ☐ No | ☐ Yes | ☐ No | ________________ |
| Chronic Lung Disease | ☐ Yes | ☐ No | ☐ Yes | ☐ No | ________________ |
| Cystic Fibrosis | ☐ Yes | ☐ No | ☐ Yes | ☐ No | ________________ |
| Dementia/Alzheimer's | ☐ Yes | ☐ No | ☐ Yes | ☐ No | ________________ |
| Diabetes | ☐ Yes | ☐ No | ☐ Yes | ☐ No | ________________ |

| | | | |
|---|---|---|---|
| Fibromyalgia | ☐ Yes ☐ No | ☐ Yes ☐ No | ________ |
| High Blood Pressure | ☐ Yes ☐ No | ☐ Yes ☐ No | ________ |
| High Cholesterol | ☐ Yes ☐ No | ☐ Yes ☐ No | ________ |
| Irritable Bowel | ☐ Yes ☐ No | ☐ Yes ☐ No | ________ |
| Kidney Disease | ☐ Yes ☐ No | ☐ Yes ☐ No | ________ |
| Migraine Headaches | ☐ Yes ☐ No | ☐ Yes ☐ No | ________ |
| Peptic Ulcer | ☐ Yes ☐ No | ☐ Yes ☐ No | ________ |
| Rheumatoid Arthritis | ☐ Yes ☐ No | ☐ Yes ☐ No | ________ |
| Stroke | ☐ Yes ☐ No | ☐ Yes ☐ No | ________ |
| Thyroid Disease | ☐ Yes ☐ No | ☐ Yes ☐ No | ________ |
| Tuberculosis | ☐ Yes ☐ No | ☐ Yes ☐ No | ________ |
| Addictions | ☐ Yes ☐ No | ☐ Yes ☐ No | ________ |
| Type? | ________ | ________ | |
| Type? | ________ | ________ | |
| Anxiety | ☐ Yes ☐ No | ☐ Yes ☐ No | ________ |
| Bipolar | ☐ Yes ☐ No | ☐ Yes ☐ No | ________ |
| Depression | ☐ Yes ☐ No | ☐ Yes ☐ No | ________ |
| OCD | ☐ Yes ☐ No | ☐ Yes ☐ No | ________ |
| Phobias | ☐ Yes ☐ No | ☐ Yes ☐ No | ________ |
| Schizophrenia | ☐ Yes ☐ No | ☐ Yes ☐ No | ________ |
| Suicide Attempts | ☐ Yes ☐ No | ☐ Yes ☐ No | ________ |
| Suicide (Completed) | | ☐ Yes ☐ No | ________ |

Other significant personal or family health issues:________________________________________

## OTHERS IN THE HOME

| Name | Age | Birth Date | Relationship to Patient |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## SIBLINGS WHO HAVE MOVED OUT OF THE HOME

| Name | Age | Birth Date | Relationship to Patient |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Please use this space for any additional information/comments you wish to share with us about your child or family.________________

____________________________________________

____________________________________________

____________________________________________

____________________________________________

____________________________________________