Print Form

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Child/Adolescent Registration Form

Date_____

_____ _____
Client Name Date of Birth

_____
Social Security Number

_____
Name of Custodial Parent(s) or Legal Guardian(s)

_____
Address (with city, state and zip code)

_____ _____ _____
Home phone Business phone Mobile phone
Permission to call? Y N Permission to call? Y N Permission to call? Y N
Permission to leave message? Y N Permission to leave message? Y N Permission to leave message? Y N

Does child have another parent with whom he or she does not live? Please indicate non-custodial parent's name, address and contact information:

_____
_____

Health Information:

_____
Significant present or previous health problems

_____
Medications child is currently taking (and dosage)

_____
Primary care physician (or Group) Phone no. Fax no.

_____
When was your child last examined by a physician?
Has your child ever received psychiatric treatment, counseling, or family counseling before?
Yes No

_____
When For how long?

Please check the issues, which are affecting your child:

- ☐ Afraid or anxious
- ☐ Shyness
- ☐ Temper tantrums
- ☐ Has no friends
- ☐ Lacks self-control
- ☐ Hyperactive
- ☐ Learning problems
- ☐ Easily distracted
- ☐ Mood Swings
- ☐ Feeling Sad
- ☐ Destroys things
- ☐ Fighting with peers
- ☐ Physical abuse
- ☐ Preoccupied with death
- ☐ Rocking/headbanging
- ☐ Sets fires, plays with matches
- ☐ Doesn't pay attention
- ☐ Seems to hear or see things others can't
- ☐ Hearing problems
- ☐ Nightmares
- ☐ Hurts self/Cutting
- ☐ Makes up stories
- ☐ Stress
- ☐ Overeating
- ☐ Poor self-esteem
- ☐ Slow development
- ☐ Feeling hopeless
- ☐ Steals
- ☐ Pulls out hair
- ☐ Loss of appetite
- ☐ Emotional abuse
- ☐ Speech problems
- ☐ Unhappiness
- ☐ Hurts others
- ☐ Defiant to adults
- ☐ On probation
- ☐ Lacks motivation
- ☐ Wetting or soiling
- ☐ Impulsiveness
- ☐ Tearfulness
- ☐ Lies
- ☐ Bullies others
- ☐ No eye contact
- ☐ Sexual abuse
- ☐ Recurrent thoughts or actions
- ☐ Doesn't like new places or people
- ☐ Alcohol or drug use
- ☐ Stays off by him or herself
- ☐ Problems with siblings
- ☐ Suicidal Thoughts
- ☐ Doesn't talk
- ☐ Cruelty to animals
- ☐ Often angry
- ☐ Sleep problems
- ☐ Argues with adults
- ☐ Seizures
- ☐ Stubborn
- ☐ Worries all the time
- ☐ Anger or irritability
- ☐ Gets teased

Briefly describe your reasons for seeking counseling at this time:

_____

_____

_____

_____

_____

_____

_____