Bloom Within Counseling
Myra Gasser, M.Ed., LPCI, RYT
grow beyond what limits you

Child and Adolescent Screening Form

ATTN: Please fill out and bring with you prior to the first meeting.

Today's date _____

Child/Adolescent Information

Child's Name _____ **Date of birth** _____

Child's race: (please circle one)
African-American Asian Caucasian Hispanic Native American
Pacific Islander Biracial (please list)_____
Other (please list) _____

School Information:

Name of School_____ Current grade _____
School address _____ City
_____
State _____ Telephone
#_____
Counselor or primary teacher
_____

Who referred you? _____
_____

Please tell us the reason for your visit to the clinic today:
_____
_____
_____
_____
_____
_____

My child/adolescent's hobbies are: _____
_____
_____
_____

Listed below are difficulties that children/adolescents sometimes have. Please circle all that describe your child/adolescent over the past year:

Aggressive	Poor academic performance
Angry	Poor concentration
Complain of aches and pains	Relationship problems with others
Difficulty hearing	Sad
Difficulty seeing	Significant change in weight
Consumes alcohol	Sleeps a lot
Eating problems	Slow to learn
Few friends	Stolen from others
Frequently sick	Suicidal thoughts
Headaches	Thoughts of death or dying
Hyper	Throws tantrums
Irritable	Tires easily
Low motivation	Uses drugs
Nervous	Uses tobacco products (cigarettes, snuff, dip)
Noncompliant (won't listen)	Wets the bed

Please provide information about preventative, punishment, and typical response methods used by parents to address the difficulties circled above (please include which methods have worked as well as ones that have not):

_____
_____
_____
_____
_____
_____

Please list current and/or past therapists/professionals seen regarding the problems identified above:

Name	Type (psychologist, counselor, psychiatrist, etc.)	Location

Please provide information about any medical conditions your child is presently being treated for.

Condition	Medication	Dose	How often

Please list any current psychiatric medications

Condition	Medication	Dose	How often

Parent/household information

Mother's name _____ **Date of birth** _____

Mother's occupation _____

Presently living in the same house as the child listed above? Yes No

Father's name _____ **Date of birth** _____

Father's occupation _____

Presently living in the same house as the child listed above? Yes No

Please list the names, ages, and relationship (example brother, sister, cousin, uncle) of the other individuals living in the same household as the child or adolescent listed above.

Name _____ Age _____ Relationship _____
Name _____ Age _____ Relationship _____
Name _____ Age _____ Relationship _____
Name _____ Age _____ Relationship _____
Name _____ Age _____ Relationship _____

Prenatal and developmental information

Please indicate if you experienced or took part in any of the following during the course of pregnancy with your child/adolescent:

Event	**1st trimester**	**2nd trimester**	**3rd trimester**
Severe cramping (pre-term labor)			
Preeclampsia (high blood pressure)			
Gestational Diabetes			
Eating Disorder			
Extreme Nausea			
Extreme Vomiting			
Smoked cigarettes			
Drank alcohol			
Took Illegal Drugs			
Caffeine (more than two drinks/day)			

Developmental milestones: Please indicate when your child reached the following milestones

Milestone	**Early**	**On time**	**Late**
Ate solid foods			
Spoke first words			
Crawled			
Recognized family members			
Walked			
Toilet trained			
Wrote his/her name			
Recognized his/her colors			
Could recite alphabet			
Played with other kids			