



**Bloom Within Counseling**  
*Myra Gasser, M.Ed., LPC, 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) \_\_\_\_\_

<b>School Information:</b>	
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):**

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

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

<b>Event</b>	<b>1<sup>st</sup> trimester</b>	<b>2<sup>nd</sup> trimester</b>	<b>3<sup>rd</sup> trimester</b>
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

<b>Milestone</b>	<b>Early</b>	<b>On time</b>	<b>Late</b>
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			

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