



Erin Garriott, LCSW

California License Number 24703

23151 Verdugo Drive, Suite 200 • Laguna Hills, CA 92653 • Ph: (949) 535-1056 • Fx: (949) 535-1075

CHILD/ADOLESCENT INFORMATION

Name: _____ DOB: _____ Sex: (M) (F)

Address: _____

Telephone: _____

Religion: _____

School/Grade: _____

CHIEF COMPLAINT: Presenting Issues (please circle all that apply)

- | | | | |
|----------------------|----------------------|------------------|--------------------|
| Very Unhappy | Lacks Initiative | Running Away | School Performance |
| Irritable | Undependable | Self-Mutilating | Truancy |
| Temper Outbursts | Peer-conflict | Head-Banging | Bed-wetting |
| Withdrawn | Phobic: _____ | Rocking | Soiled Pants |
| Daydreaming | Impulsive | Shy | Eating Problems |
| Fearful | Stubborn | Strange Behavior | Sleeping Problems |
| Clumsy | Disobedient | Strange Thoughts | Sickly |
| Overactive | Infantile | Fire Setting | Drug/Substance Use |
| Slow | Mean to Others | Stealing | Alcohol Use |
| Short Attention Span | Destructive | Lying | Suicide Talk |
| Distractible | Trouble with the Law | Sexual Trouble | |

How long have these problems occurred? (# of weeks, months, years?)

What happened that makes you seek help at this time?

Problems perceived to be: Very Serious Serious Not Serious

What are your expectations of your child?

What changes would you like to see in yourself?

What changes would you like to see in your family?

What are the major family stresses at the present time, if any? (i.e. health, financial, etc.)

CHILD HEALTH INFORMATION: (Please not all health problems the child has had or has now.)

	(Age)		(Age)
<input type="checkbox"/> High Fevers	_____	<input type="checkbox"/> Dental Problems	_____
<input type="checkbox"/> Pneumonia	_____	<input type="checkbox"/> Weight Problems	_____
<input type="checkbox"/> Flu	_____	<input type="checkbox"/> Allergies	_____
<input type="checkbox"/> Encephalitis	_____	<input type="checkbox"/> Skin Problems	_____
<input type="checkbox"/> Meningitis	_____	<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Convulsions	_____	<input type="checkbox"/> Headaches	_____
<input type="checkbox"/> Unconsciousness	_____	<input type="checkbox"/> Stomach Problems	_____
<input type="checkbox"/> Concussions	_____	<input type="checkbox"/> Accident Prone	_____
<input type="checkbox"/> Head Injury	_____	<input type="checkbox"/> Anemia	_____
<input type="checkbox"/> Fainting	_____	<input type="checkbox"/> High/Low Blood Pressure	_____
<input type="checkbox"/> Dizziness	_____	<input type="checkbox"/> Sinus Problems	_____
<input type="checkbox"/> Tonsils Out	_____	<input type="checkbox"/> Heart Problems	_____
<input type="checkbox"/> Vision Problems	_____	<input type="checkbox"/> Hyperactivity	_____
<input type="checkbox"/> Hearing Problems	_____	<input type="checkbox"/> Other Illnesses _____	
<input type="checkbox"/> Earaches	_____	_____	_____

Current Medications (include nonprescription): _____

Primary Care Physician & Date of Last Check-Up: _____

Previous Hospitalizations/Surgeries/Serious Illnesses		
Event	When	Hospital, City, State

DEVELOPMENTAL MILESTONES:

Within Normal Range Delayed (explain)_____

EARLY SOCIAL DEVELOPMENT:

Relationship to siblings and peers: Individual Play Group Play Competitive
 Cooperative Leadership Role A Follower

Describe special habits, fears, or idiosyncrasies of the child:

EDUCATIONAL HISTORY:

Types of Classes: Regular Education Special Day Class Continuation
 Emotionally Disturbed Opportunity Other_____

Did your child skip a grade: Yes No Repeat a grade: Yes No

Does your child... Have any learning difficulties? Yes No
Appear motivated for school? Yes No

Has your child... Needed special help with school work? Yes No
Ever been suspended or expelled? Yes No

Highest grade on last report card?

Lowest grade on last report card?

Favorite subject?

Least favorite subject?

Extracurricular activities? Yes No (Explain)

In school, how many friends does your child have? A lot A few None

CHILD'S INTERESTS/HOBBIES:

ADDITIONAL COMMENTS: