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) (Non-binary)

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Withdrawn	Phobic:_____	Rocking	Soiled Pants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)
☐ High Fevers	_____	☐ Dental Problems	_____
☐ Pneumonia	_____	☐ Weight Problems	_____
☐ Flu	_____	☐ Allergies	_____
☐ Encephalitis	_____	☐ Skin Problems	_____
☐ Meningitis	_____	☐ Asthma	_____
☐ Convulsions	_____	☐ Headaches	_____
☐ Unconsciousness	_____	☐ Stomach Problems	_____
☐ Concussions	_____	☐ Accident Prone	_____
☐ Head Injury	_____	☐ Anemia	_____
☐ Fainting	_____	☐ High/Low Blood Pressure	_____
☐ Dizziness	_____	☐ Sinus Problems	_____
☐ Tonsils Out	_____	☐ Heart Problems	_____
☐ Vision Problems	_____	☐ Hyperactivity	_____
☐ Hearing Problems	_____	☐ Other Illnesses_____	
☐ 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 schoolwork? ☐ 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: