

# Child/Adolescent Update

Please complete this form to the best of your knowledge.

## PATIENT IDENTIFICATION

Child's Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone # \_\_\_\_\_  
Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Mother's Preferred Phone#: \_\_\_\_\_  
Mother's Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Father's Preferred Phone#: \_\_\_\_\_  
Father's Address: \_\_\_\_\_

Who is the child currently living with? \_\_\_\_\_  
Legal Guardian: \_\_\_\_\_  
Name of person completing this form \_\_\_\_\_

## Emergency Information

In case of emergency, contact:  
Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**It is your responsibility to inform Milestone Counseling of changes in address, phone number, and insurance coverage.**

**It is often beneficial to provide or exchange information with your other health providers for the most complete care. Are you willing to sign a Release of Information form so that we may coordinate care with your other providers?** \_\_\_No \_\_\_Yes

Current concerns you have for your child : \_\_\_\_\_  
\_\_\_\_\_

**Goals:** When my child is done with therapy they will... \_\_\_\_\_  
\_\_\_\_\_

## What skills would you and your child like to build?

\_\_\_ Ability to manage stress                      \_\_\_ Increase ability to express feelings  
\_\_\_ Anxiety management                        \_\_\_ Conflict resolution  
\_\_\_ Following directions                        \_\_\_ Build self-esteem  
\_\_\_ Build confidence in skills and abilities    \_\_\_ Problem solving skills  
\_\_\_ Build parenting strategies                \_\_\_ Improve mood  
\_\_\_ Improve ability to accept "no"            \_\_\_ Improve ability to cope with change  
\_\_\_ Improve social skills                        \_\_\_ Improve cooperation with rules  
\_\_\_ Ability to more appropriately express anger/frustration  
\_\_\_ Having appropriate boundaries with others  
Other: \_\_\_\_\_

**Strengths**

- Good at reading                       Good at math                       Confident                       Caring
- Tries hard at school                       Organized                       Wise                       Athletic
- Enthusiastic                       Good friend                       Helpful                       Nature enthusiast
- Trustworthy                       Positive                       Observant                       Considerate
- Good listener                       Adventurous                       Independent                       Appreciative
- Creative
- Good with animals
- Other: \_\_\_\_\_

**Current Activities or Interests:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY IDENTIFICATION AND HISTORY**

Please name each person (including parents, stepparents, adoptive parents, or full, half or step siblings) **CURRENTLY** living in the same household as this child:

**Primary Household**

Name	Relationship to child	Age	Grade or Occupation	Quality of Relationship

**Secondary Household (if applicable)**

Name	Relationship to child	Age	Grade or Occupation	Quality of Relationship

**Custody and Parenting Plan:**  Lives with both parents    Single parent    Shared Custody  
 Current Parenting Schedule if shared custody: \_\_\_\_\_

**Life Stressors** (Please mark any life stressors that are currently impacting your child):

- Moved     Changed school
- School harassment, bullying, or violence                       Serious illness or injury in family
- Family financial problems                       Job change in family
- Parent starting work outside home                       Support group deficit
- Divorce or separation                       Sibling leaving home
- Family legal problems                       Educational struggles
- Parental conflict/family violence                       Housing inadequate

## Current Symptoms

When reviewing these symptoms, please mark only those behaviors that are occurring more often than you would typically see for someone at your child's stage of development.

### Group A

- |  |  |
|--|--|
| <input type="checkbox"/> Persistently sad or unhappy                   | <input type="checkbox"/> Irritable                         |
| <input type="checkbox"/> Low self-esteem                               | <input type="checkbox"/> Feelings of worthlessness         |
| <input type="checkbox"/> Loss of interest in things previously enjoyed | <input type="checkbox"/> Difficulty concentrating          |
| <input type="checkbox"/> Anger and rage                                | <input type="checkbox"/> Suicidal comments                 |
| <input type="checkbox"/> Recurrent thoughts of death                   | <input type="checkbox"/> Engaging in self-harming behavior |
| <input type="checkbox"/> Socially isolating/avoiding others            | <input type="checkbox"/> Crying easily/frequently          |
| <input type="checkbox"/> Grades have dropped                           | <input type="checkbox"/> Loneliness                        |
| <input type="checkbox"/> Headaches, stomachaches, etc. without cause   |  |
- Changes in appetite:  Increase  Decrease
- Changes in sleep pattern:  trouble falling asleep  trouble staying asleep  sleeping a lot
- Changes in activity level:  low energy  more restless than usual

### Group B

- |  |  |
|--|--|
| <input type="checkbox"/> abrupt, rapid mood swings   | <input type="checkbox"/> periods of <u>extreme</u> hyperactivity   |
| <input type="checkbox"/> excessive talkativeness   | <input type="checkbox"/> exaggerated ideas about self or abilities |
| <input type="checkbox"/> decreased need for sleep  | <input type="checkbox"/> racing thoughts                           |
| <input type="checkbox"/> engaging in risky behaviors   |  |
| <input type="checkbox"/> prolonged, explosive temper tantrums or rages that are out of the range of normal for their developmental level |  |
| <input type="checkbox"/> severe and persistent irritability nearly every day   |  |

### Group C

- |  |  |
|--|--|
| <input type="checkbox"/> excessive anxiety and worry   | <input type="checkbox"/> test anxiety                  |
| <input type="checkbox"/> child has a hard time turning off worries   | <input type="checkbox"/> difficulty concentrating      |
| <input type="checkbox"/> restlessness  | <input type="checkbox"/> excessive shyness             |
| <input type="checkbox"/> muscle tension  | <input type="checkbox"/> easily fatigued               |
| <input type="checkbox"/> irritability  | <input type="checkbox"/> difficulty sleeping           |
| <input type="checkbox"/> need for perfection   | <input type="checkbox"/> lacks confidence in abilities |
| <input type="checkbox"/> intense distress when separating from parent figure   |  |
| <input type="checkbox"/> nightmares involving theme of separation  |  |
| <input type="checkbox"/> refusal to go to school because of fear of separation   |  |
| <input type="checkbox"/> persistent worry about something bad happening to a parent figure   |  |
| <input type="checkbox"/> persistent fear of a life event separating the child from the parent  |  |
| <input type="checkbox"/> persistent fear or reluctance of being alone or without parent figure   |  |
| <input type="checkbox"/> refusal to go to sleep without parent figure nearby   |  |
| <input type="checkbox"/> complaints of physical symptoms (headaches, stomachaches, nausea, diarrhea)   |  |
| <input type="checkbox"/> excessive and unreasonable fear of an object or situation: <input type="checkbox"/> getting shots <input type="checkbox"/> vomiting <input type="checkbox"/> bugs                                     |  |
| <input type="checkbox"/> <input type="checkbox"/> dark <input type="checkbox"/> seeing blood <input type="checkbox"/> other: _____   |  |
| <input type="checkbox"/> compulsive behaviors: <input type="checkbox"/> counting <input type="checkbox"/> hoarding <input type="checkbox"/> checking <input type="checkbox"/> organizing <input type="checkbox"/> hand washing |  |
| <input type="checkbox"/> repeating words <input type="checkbox"/> other: _____   |  |
| <input type="checkbox"/> obsessive thoughts, impulses or mental images that cause the child significant distress or anxiety  |  |

### **Group D**

- \_\_\_ often fidgets with hands or feet, or squirms in seat
- \_\_\_ often leaves seat in situations in which remaining seated is expected
- \_\_\_ running or climbing in situations where that is inappropriate
- \_\_\_ blurts out answers to questions before they have been completed
- \_\_\_ talks excessively
- \_\_\_ often interrupts or “butts in” to others’ games
- \_\_\_ often has difficulty waiting in line or taking turns
- \_\_\_ difficulty playing quietly
- \_\_\_ very restless, as if “driven by a motor”
- \_\_\_ easily distracted
- \_\_\_ does not seem to listen
- \_\_\_ tendency to seek instant gratification
- \_\_\_ often loses things necessary for tasks or activities (school assignments, pencils, books)
- \_\_\_ seems disorganized, loses things needed for school
- \_\_\_ act without considering the consequences
- \_\_\_ is often forgetful in daily activities
- \_\_\_ makes careless mistakes on schoolwork or other activities/fails to pay attention to details
- \_\_\_ often does not follow through on instructions

### **Group E**

- \_\_\_ often loses temper
- \_\_\_ often refuses to follow rules or adults’ requests
- \_\_\_ often deliberately does things to annoy others
- \_\_\_ often blames others for mistakes/misbehavior
- \_\_\_ often argues with parents or teachers
- \_\_\_ is often angry or resentful
- \_\_\_ is often spiteful or vindictive
- \_\_\_ is often touchy; easily annoyed by others

### **Group F**

- \_\_\_ often bullies, threatens or intimidate others
- \_\_\_ skips school
- \_\_\_ has deliberately destroyed others’ property
- \_\_\_ has been physically cruel to other people
- \_\_\_ sets fires/dangerous play with fire
- \_\_\_ has broken into someone else’s house or car
- \_\_\_ has stolen while confronting the victim
- \_\_\_ has stolen small items without confronting the victim
- \_\_\_ often stays out late at night without permission before the age of 13
- \_\_\_ often lies or “cons” others
- \_\_\_ is cruel to animals
- \_\_\_ often starts physical fights
- \_\_\_ doesn’t seem sorry for hurting others
- \_\_\_ has forced someone into sexual activity
- \_\_\_ runs away overnight

### **Group G**

- \_\_\_ alcohol use
- \_\_\_ drug use
- \_\_\_ smoking

### **Group H**

- \_\_\_ difficulty making friends
- \_\_\_ difficulty keeping friends
- \_\_\_ poor choice of friends

### **Group I**

- \_\_\_ recurrent and upsetting thoughts of a past traumatic event \_\_\_\_\_
- \_\_\_ recurrent distressing dreams of a past upsetting event
- \_\_\_ a sense of reliving a past upsetting event
- \_\_\_ a sense of panic or fear to events that resemble an upsetting past event
- \_\_\_ spending effort avoiding thoughts or feelings associated with a past trauma
- \_\_\_ inability to recall an important aspect of a past upsetting event
- \_\_\_ persistent avoidance of activities or situations that cause him/her to remember a past upsetting event
- \_\_\_ marked decreased interest in important activities

- \_\_\_ feeling detached or distant from others
- \_\_\_ feeling numb or restricted in your feelings
- \_\_\_ feeling that his/her future is shortened
- \_\_\_ quick startle response
- \_\_\_ feeling like he/she is always watching for bad things to happen
- \_\_\_ when recalling the trauma the child tends to put the events in the wrong sequence of when things happened
- \_\_\_ child believes that there were warning signs predicting the trauma and that if they are aware enough they can recognize warning signs to avoid future trauma.
- \_\_\_ compulsively re-enacts some part of the traumatic experience through play

### **Group J**

- \_\_\_ poor use of nonverbal behaviors (such as eye-to-eye gaze, facial expression, body postures and gestures to regulate social interactions)
- \_\_\_ failure to develop peer relationships
- \_\_\_ lack of showing, bringing, or pointing out objects of interest to other people
- \_\_\_ lack of social or emotional exchanges with others
- \_\_\_ regularly gets overwhelmed or upset when their routines or expectations are disrupted
- \_\_\_ hand or finger flapping or twisting
- \_\_\_ difficulty identifying when someone is teasing
- \_\_\_ fails to predict likely consequences in social situations
- \_\_\_ difficulty making believe or pretending
- \_\_\_ talks about a single subject excessively (e.g.: dinosaurs, computers, fire trucks, a game, etc..)
- \_\_\_ shows an intense, obsessive interest in certain intellectual subjects
- \_\_\_ unaware of, or insensitive to the needs or feelings of others
- \_\_\_ demonstrates bizarre or unusual forms of behavior
- \_\_\_ preoccupation with specific subjects or parts of objects
- \_\_\_ expresses feelings of empathy inappropriately
- \_\_\_ seems unaware of social norms or codes of conduct
- \_\_\_ becomes frustrated quickly when unsure of what is required
- \_\_\_ displays clumsy and uncoordinated gross motor movements

### **Group K**

- \_\_\_ restriction of food intake that leads to a less than normal body weight
- \_\_\_ intense fear of gaining weight or of becoming fat even though at a significantly low weight
- \_\_\_ engaging in persistent behaviors that interfere with weight gain
- \_\_\_ persistent over concern with body shape and weight
- \_\_\_ lack of recognition of the seriousness of the current low body weight
- \_\_\_ recurrent episodes of binge eating large amount of food
- \_\_\_ eating, in a certain time frame, larger amounts of food than most people would eat in the same time
- \_\_\_ a sense of lack of control over eating during the episode
- \_\_\_ engaging in self-induced vomiting
- \_\_\_ the misuse of laxatives, water pills, strict dieting or excessive exercise

## Physical Health Update

Describe your child's current physical health:  Excellent  Good  Fair  Poor

Is your child currently under the care of a doctor/health provider?  No  Yes

If yes, Name: \_\_\_\_\_ Clinic: \_\_\_\_\_

Current medical diagnosis or concerns? \_\_\_\_\_

What medications is your child currently taking?

Medication \_\_\_\_\_ Dose: \_\_\_\_\_

Medication \_\_\_\_\_ Dose: \_\_\_\_\_

Medication \_\_\_\_\_ Dose: \_\_\_\_\_

## Mental Health Update

Is your child currently under the care of a psychiatrist?  No  Yes

If yes, Name: \_\_\_\_\_ Clinic: \_\_\_\_\_

Has child recently been hospitalized for mental health issues or suicidal thoughts?

No  Yes/Facility: \_\_\_\_\_ Date: \_\_\_\_\_

Has your child participated in other therapy (group, individual, family) recently?  Yes  No

If yes, what clinic or provider did your child see? \_\_\_\_\_

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