Youth For Tomorrow
for Gibbs Founder
OUTPATIENT SERVICES

14000 Crown Court, Ste. 101
Woodbridge, VA 22913
Phone: 703-396-7215 Fax: 571-285-5686

9720 Capital Court, Ste. 302
Manassas, VA 20110
Phone: 703-396-8618 Fax: 571-364-8913

7130 Heritage Village Plaza, Ste. 102
Gainesville, VA 20155
Phone: 703-955-3187 Fax: 703-743-1688

CHILDREN & ADOLESCENT INFORMATION SHEET

Date ___/____/_____ Referred by:_____

CLIENT INFORMATION

Name: _____ Age:_____ D.O.B. ____/____/____

Grade: _____ School:_____

Child's Custodian, Parent, Guardian (s):_____

_____

Child's Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Other: _____

Child lives with: ☐ Mother and Father ☐ Mother only ☐ Father only ☐ Adoptive Parent(s)

☐ Mother & Step Parent/Other ☐ Father & Step Parent/Other

☐ Foster Care Provider ☐ Other: _____

Legal Custody is with: _____

MOTHER'S INFORMATION

Mother's Name: _____ Age: _____

Mother's Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Occupation: _____

Employer: _____

Mother's Marital Status: ☐ Married ☐ Engaged ☐ Widowed ☐ Divorced ☐ Separated

☐ Lives with Partner ☐ Other: _____

FATHER'S INFORMATION

Father's Name: _____ Age: _____

Father's Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Occupation: _____

Employer: _____

Father's Marital Status: ☐ Married ☐ Engaged ☐ Widowed ☐ Divorced ☐ Separated

☐ Lives with Partner ☐ Other: _____

FAMILY STRUCTURE

Please list all individuals that reside in the same house as the child (grandparents, half/ step siblings, etc.)

Please include all their name, age and relationship to the child.

Name	Age	Relationship to Child

MEDICAL AND DEVELOPMENTAL HISTORY

Has your child had counseling before? ☐ No ☐ Yes, When? _____

Counselor/Therapist Name: _____

Agency's Name: _____

Agency's Address: _____

City: _____ State: _____ Zip Code: _____

Main Phone: _____ Fax Phone: _____

Outcome: _____

Diagnosis: _____

Date of last medical exam: _____

Please rate your child's health: ☐ Excellent ☐ Good ☐ Average ☐ Poor

Has your child ever been hospitalized for mental health issues? ☐ Yes ☐ No If so, please explain below.

_____

_____

Developmental Milestones ☐ On-time, no issues ☐ Delayed, Explain: _____

_____

Head trauma or Surgeries: _____

Sensory processing issues: _____

Is your child on medication? ☐ Yes ☐ No If so, please provide the following information.

	Name of Drug	Dosage	For what?
1.			
2.			
3.			
4.			
5.			
6.			

Does your child have any known alcohol or drug use? ☐ No ☐ Yes ☐ Uncertain If so, please explain below.

_____

_____

EDUCATION

Setting: ☐ Public ☐ Private ☐ Charter ☐ Homeschool

Special Education? ☐ No ☐ Yes Services:_____

IEP or 504 Plan? ☐ No ☐ Yes Accommodations:_____

REASON FOR SERVICES

What concern has caused you to bring your child in for counseling at this time?

_____

_____

_____

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What has been done about your concern up to this present time?

Has anyone in the family experienced similar problems?

What is your assessment of the child's personality? Strengths, weaknesses, etc.

How would your child describe the problem?

What is the current family and school situation?

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How does the child interact with other members of the family?

_____

_____

How does the child handle stress?

_____

_____

_____

Is there any other information you think we should know about?

_____

_____

_____

_____ _____
Client Signature Date

_____ _____
Parent/Legal Guardian/ Caregiver Signature Date

_____ _____
YFT Staff Signature/ Credentials Date