Youth For Tomorrow
Joe Gibbs Founder
OUTPATIENT SERVICES

19415 Deerfield Ave, Ste. 101 Lansdowne, Virginia 20176
Phone # 703-659-1433 / Fax # 703-723-7222

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: _____

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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: _____

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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?

Do not upload. For assessment only.