Kirby Creative Clinical Solutions, LLC
3929 Old Lee Hwy; Unit 92-D
Fairfax, VA 22030
703-409-2571
Tax ID # 27-2924949

Adolescent Client Information

Name: ____ Date of Birth:________________

Address: ____ Preferred Pronouns ____________

____

School: ____ Grade _______ Age ________

Home Phone: _______________________________________ ☐

Work Phone: _______________________________________ ☐

Cell Phone: _______________________________________ ☐

Email: ____ ☐

****To be completed by adolescent client****

What are your strengths; what are you good at?

What are your hobbies? Activities? Things you like to do?

Who are your closest friends and what do you like to do when you hang out together?

What things are bothering you most in your life at this time?

What signs would tell you that things are getting better in your life?

Please list anyone we could talk to help us better understand what is going on and how we can help?

Parent / Guardian # 1

Name:____ Relationship:_________________________

Address: ____

____

Occupation(s): ____

Home Phone: ____ ☐

Work Phone: ____ ☐

Cell Phone: ____ ☐

Email: ____ ☐

Parent / Guardian # 2

Name:____ Relationship:_________________________

Address: ____

____

Occupation(s): ____

Home Phone: ____ ☐

Work Phone: ____ ☐

Cell Phone: ____ ☐

Email: ____ ☐

Emergency Contact

Name:____ Relationship:_________________________

Address: ____

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Home Phone: ____ ☐

Work Phone: ____ ☐

Cell Phone: ____ ☐

Email: ____ ☐

Referral Source: ____

Can be completed by client or parent / guardian:
Primary reason for seeking counseling / support:

____

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____

____

When did this concern begin? ____

What has been tried to resolve this concern? ______________________________________

Any Diagnosis: ____

Current Medications: ____

Family Information and History

Who lives in your home? (Include names, ages, and relationship to you) ______________________

____

____

Describe your relationship with each parent/caregiver. ______________________________

____

____

Describe your relationship with each sibling. ___________________________________

____

____

List any <u>family history</u> of medical illnesses, mental illnesses, and/or substance abuse concerns.

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____

List any current medications or diagnoses either <u>parent</u> is being treated for.

____

____

Blended, separated, or divorced families please complete the following:

When did the divorce/separation occur? ____

What was your initial reaction to the news? ____

How was custody arranged? ____

____

How often does you see the non-custodial parent? ____

Describe your relationship with each parent. ____

____

____

Please describe each parent's current situation in terms of significant other, remarriage, step children, etc. Provide names and ages for all relevant persons.

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Describe your relationship with step-parents, stepsiblings, half-siblings, significant others.

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<u>Parent</u> Additional Information and Feedback
Social / Developmental

Please provide any information regarding the pregnancy, delivery and developmental milestones for your child.

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Describe your child as a baby. ____

Describe your child as a toddler. ____

Describe your child in elementary school. ____

What are your child's strengths and interests? ____

____

List your child's extracurricular activities. Include length of time (month, years) involved. _____________

____

Does your child have a close group of friends? Yes ___ No ___

Describe your child's friendships and social skills____

____

Does your child drive? Yes ___ No ___

Does your child date? Yes ___ No ___

Is your child currently in a relationship with a significant other? Yes ___ No ___If yes, how long? _______

Is your child sexually active? Yes ___ No ___

Has your child ever been pregnant? Yes ___ No ___

To your knowledge, does your child, or have they ever, used tobacco, alcohol or other drugs? Please describe:

____

____

Any other information you'd like to provide:

<u>Parent</u> Additional Information and Feedback
Medical / Mental Health

Has your child had any serious medical issues, now or in the past? Yes ___ No ___ Please provide details.

____

____

Has your child ever received mental health treatment before? Yes ___ No ___ If yes, please provide details.

____

____

Has your child ever been hospitalized for emotional difficulties? Yes ___ No ___ If yes, please provide details

____

____

Has your child ever talked about / attempted suicide or attempted self-harm, such as cutting? Yes ___ No ___

____

____

Has your child ever talk about or attempted to seriously harm another person? Yes ___ No ___

____

____

Has your child ever attempted to kill or seriously harm an animal? Yes ___ No ___

____

____

Has your child ever attempted to start a fire or destroy property in any way? Yes ___ No ___

____

____

<u>Parent</u> Additional Information and Feedback
Academic History

List the schools your child has attended:

Name of School	City, State	Grade(s)

Has your child ever been retained or repeated a grade? Yes ___ No ____

Has your child ever taken advanced placement classes? Yes ____ No ____

Has your child had a 504 plan or an Individualized Education Plan (IEP)? Yes ___ No ____

If yes, please list school accommodations. ____

____

Has your child ever been suspended or expelled from school? Yes ____ No____ If yes, please list details _____

____

Has your child ever had any previous psychological or educational evaluations? Yes ___ No ____ If yes, please summarize the findings. ____

____

Please provide a copy of all evaluations.

Any other information you'd like to provide:

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