



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

PASSPORT Client Name: _____

Address: _____ Date of Birth: _____

Parent / Guardian # 1

Name: _____ Relationship: _____

Address: _____

Occupation: _____

Phone # 1: _____

Phone # 2: _____

Email: _____

Parent / Guardian # 2

Name: _____ Relationship: _____

Address: _____

Occupation: _____

Phone # 1: _____

Phone # 2: _____

Email: _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____

Phone # 1: _____

Phone # 2: _____

Email: _____

Referral Source: _____

Parent / Guardian Reason for Referral:

When did this concern begin? _____

What has been tried to resolve this concern? _____

Any Diagnosis: _____

Current Medications: _____

Family Information and History

Who lives in the home? (Include names, ages, and relationship to the child) _____

Describe your child's relationship with each parent/caregiver. _____

Describe your child's relationship with each sibling. _____

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

List any current medications or diagnoses either parent is being treated for.

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

When did the divorce/separation occur? _____

How did your child initially react to the news? _____

How is custody arranged? _____

How often does your child see the non-custodial parent? _____

Describe your child's 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.

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

**Parent Additional Information and Feedback
Social / Developmental**

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

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:

Does your child have access to a firearm, either of their own or in the house? Yes ___ No ___

Parent 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 ___

**Parent 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:

