CHARLES A. SCHAEFER, PH.D., INC.
Confidential Child and Adolescent Data Form

Please answer the following questions as completely as possible.

Child's Name_____ M ___ F ___ Birth Date_____

Today's Date_____ Form Completed by _____

Your Relationship to the Child _____

Child's School/Day Care Center_____ Grade _____ Age _____

Child's Primary Physician_____ Phone _____

Consent

I request and authorize the staff of Charles A. Schaefer, Ph.D., Inc. to provide evaluation and/or treatment to my minor child: _____.

I attest that I am his/her legal custodial parent and that I am legally entitled to authorize evaluation and treatment.

_____ _____

Parent or guardian's signature(s) Date

_____ _____

Printed Name(s) Relationship to Child

Family Information:

Mother's Name_____ Date of Birth_____

Mother's occupation_____ #hrs/week_____ Education_____

Living in Home?_____ If no, explain_____

Father's Name_____ Date of Birth_____

Father's occupation_____ Education_____

Living in Home?_____ If no, explain_____

With whom does the child live? Birth Parents _____ Foster Parents _____

Adoptive Parents _____ Other (Specify) _____

Others who live in the home: _____

_____

In Case of Emergency notify (or specify Mother/Father above):

Name_____ Relationship_____

Address_____ City_____ State_____ Zip_____

Work Phone_____ Home Phone _____ Cell Phone_____

Insurance Company: _____ ID# _____ Group#_____

Policyholder_____ Policyholder's Date of Birth_____

Claims Address_____ City_____ State_____ Zip_____

Employer_____ Copay, if known _____

Parent Concerns:

What is the primary reason you are seeking help for your child at this time?_____

_____

_____

When did these problems begin?_____

What do you think are the causes of your child's problems?_____

_____

What have you been told by doctors, teachers, and/or others about your child's problem(s)?_____

_____

_____

Has this child had any other mental health evaluations or treatment? _____

_____

_____

Educational evaluations, occupational or physical therapy, or speech or language evaluations? _____

_____

_____

Has any other member of the child's immediate family had mental health treatment? _____

_____

_____

Please describe any marital problems or family stresses which may contribute to your child's problems:

_____

_____

Please describe any other unusually severe stresses your child has experienced during the past year: _____

_____

_____

What has been done so far to try to deal with your child's problem? _____

_____

Please list any special strengths or talents that your child has:

_____

Medical Information:

Does or has your child had any significant medical problems? If so, please describe: _____

_____

_____

List any medications your child is taking, or has taken, on an ongoing basis:

Name	*Dosage*	*Frequency*	*Start Date*	*MD*
_____		_____	_____	_____
_____		_____	_____	_____
_____		_____	_____	_____

Has your child ever been hospitalized? If yes, briefly explain: _____

_____

Child's Developmental History:

Pregnancy and birth, any problems? No ___ Yes ____ If Yes, Briefly Explain _____

_____

Was the child adopted? _____ If yes, at what age? _____ What History/Information is know about the birth parents? _____

_____

_____

_____

Developmental Milestones (at what ages were these met?)

Sitting _____ Walking _____ Talking _____ Toilet Trained _____

Medical Problems? No _____ Yes_____ If yes, briefly explain _____

_____

_____

Please list any jobs or chores your child has in the family or at school. (Feeding the dog, taking out trash, safety patrol). If none _____

1. _____
2. _____
3. _____

How well does your child do these jobs or chores?

Poor 1 2 Average 3 4 Great 5

_____

_____

_____

Comments: _____

Compared to other children his/her age how does your child get along with other children?

Poor 1 2 Average 3 4 Great 5

What are your child's favorite recreational or extracurricular activities? _____

_____

Who generally disciplines the child? _____

What methods are used? _____

Do parents agree about the method of discipline? Yes _____ No _____ If No, please explain:
_____

School History:

What is the present school grade? _____

If your child has been to school (including preschool, kindergarten, elementary, etc.) complete the following for all classes and end with the current placement. Please comment if your child repeated a grade or is in a special class (gifted, leaning disabled, curriculum assistance, behaviorally/emotionally handicapped, etc.).

Grade(s) *School* *Comments*

_____

_____

_____

_____

_____

Current School performance (for children aged 6 and older)

	Failing	Below Average	Average	Above Average
Reading	_____	_____	_____	_____
Writing	_____	_____	_____	_____
Math	_____	_____	_____	_____
Spelling	_____	_____	_____	_____

Other academic subjects (History, Science, Art, Music, Languages, etc)

	Failing	Below Average	Average	Above Average
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Behavior problems in school? _____
_____

_____

How much are each of the following areas a problem to your child?

	Not at All	A Little	Somewhat	Considerably	Terribly
Anxiety	0	1	2	3	4
Physical problems	0	1	2	3	4
Depression	0	1	2	3	4
Alcohol abuse	0	1	2	3	4
Drug abuse	0	1	2	3	4
Family conflicts	0	1	2	3	4
Marital conflicts	0	1	2	3	4
Social relationships	0	1	2	3	4
Job/school conflicts	0	1	2	3	4
Sexual problems	0	1	2	3	4
Spiritual/religious	0	1	2	3	4
Legal	0	1	2	3	4
Eating disorder	0	1	2	3	4
Abuse (physical, emotional, sexual)	0	1	2	3	4

Any other information that you think may be helpful about your child: _____

_____

_____

_____

THERAPIST-CLIENT SERVICES AGREEMENT
CHARLES A. SCHAEFER, PH.D., INC.

I. I have received a copy of the Charles A. Schaefer, Ph.D., Inc. THERAPIST-CLIENT SERVICES AGREEMENT and a copy of the Charles A. Schaefer, Ph.D., Inc. PRIVACY NOTICE. (These forms are available on the practice website at www.CharlieSchaefer.com.)

_____
Initials/ Date

II. ***(This must be initialed and signed by your first session.)***

I have read, understand, and accept the following by initialing each item:

_____ that Charles A. Schaefer, Ph. D., Inc. may disclose Protected Health Information as necessary to my insurance company if I want my insurance to be filed. If this is not initialed, I understand that I must pay in full for services.

_____ that Charles A. Schaefer, Ph.D., Inc. may use Protected Health Information within the practice for the purpose of Treatment/Consultation

_____ that Charles A. Schaefer, Ph.D., Inc. may share Information as necessary with my primary care physician. If you do not wish information to be shared with your physician initial the "no" block below.

____ NO, do not share information with my physician

Please initial the following if Charles A. Schaefer, PhD., Inc. staff:

_____ may contact you or leave messages at your **home** telephone number

_____ may contact you or leave messages at your **work** telephone number

_____ may contact you or leave messages at your **cell phone** telephone number

_____ may contact you by **e-mail.** If yes, specify address_____

I have read, understand, and accept all of the provisions of the Charles A. Schaefer, Ph.D., Inc. THERAPIST-CLIENT SERVICES AGREEMENT and the Charles A. Schaefer, Ph.D., Inc. PRIVACY NOTICE.

_____ _____
Name (Parent or Representative) Date

_____
Relationship to Patient/Client