

Clinical Interview Form-Child

Date: _____

Name: _____

Address: _____

City: _____ Zip Code: _____

Phone Number: _____

Parent Names: _____

Parent Contact Phone #'s _____

Child's DOB: _____ Age: _____ Race: _____

Languages Spoken: _____

Insurance Information

Health Plan/Insurance: _____ Policy #: _____

Subscriber Name: _____ Subscriber SS# _____

Employer: _____

Presenting Problem

(Reason for seeking services)

Onset: _____ Frequency: _____

Duration: _____ Severity: _____ Mild _____ Moderate _____

Severe _____

Patient Name: _____

Signs and Symptoms of Impairment(s)

(e.g., social, educational, affective, cognitive, physical)

History of Presenting Problem

Events, precipitating factors, stressors, and/or incidents leading to need for services:

Was there a clear time when Sx worsened? _____

Family mental health history: _____

Current Family and Significant Relationships

Strengths/support: _____

Stressors/problems: _____

Recent changes: _____

Changes desired: _____

Comment on family circumstances: _____

Childhood/Adolescent History

(Developmental milestones, past behavioral concerns, environment, abuse, school, social, mental health)

Social Relationships

Strengths: _____

Weaknesses: _____

Patient Name: _____

Education

Current School _____ Grade level: _____

In special education? No Yes (describe) : _____

Strengths: _____

Weaknesses: _____

Leisure/Recreational

Hobbies _____

Physical Health/Medical History

Has child ever had a head injury? _____ When? _____

Loss of consciousness? _____ How long? _____

Counseling/Prior Treatment History

Benefits of previous treatment: _____

Setbacks of previous treatment: _____

Current Medications: _____

Other Diagnostic Concerns or Behavioral Issues

Please check all that apply: eating difficulties sleep impairment

impulse control problems thought disorders anger issues

relationships problems phobias suicidal ideation

Anxiety Depressed mood irritability obsessive or compulsive behavior