

Flores Center for Family Counseling, Inc  
65 N. Madison Ave, Suite 411, Pasadena, CA. 91101

Initial Child/Adolescent Questionnaire

Today's Date: \_\_\_\_\_

Youth's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

H Phone ( ) \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Teacher \_\_\_\_\_ Counselor \_\_\_\_\_ School Address \_\_\_\_\_

Insurance Carrier (if applicable) \_\_\_\_\_

**FAMILY/GUARDIAN INFORMATION**

Father's Name \_\_\_\_\_ Age \_\_\_\_\_

Mother's Name \_\_\_\_\_ Age \_\_\_\_\_

Address(es) \_\_\_\_\_

Address(es) \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

H Phone ( ) \_\_\_\_\_

H Phone ( ) \_\_\_\_\_

W Phone ( ) \_\_\_\_\_

W Phone ( ) \_\_\_\_\_

Occupation \_\_\_\_\_

Occupation \_\_\_\_\_

Education \_\_\_\_\_

Education \_\_\_\_\_

Please list all others living in the home and immediate family outside the home.

Name Age Relationship

Name Age Relationship

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Previous marriage(s) for either spouse? \_\_\_\_\_ Married \_\_\_\_\_ times(s) \_\_\_\_\_ years

Children by previous marriage(s)? \_\_\_\_\_

Significant Others (eg. Step-parent, Guardian) \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**MEDICAL HISTORY**

Child/Adolescent Physician/Pediatrician \_\_\_\_\_ Address/Phone \_\_\_\_\_

Date of last physical \_\_\_\_\_ Current Medications (dosages) \_\_\_\_\_

Approximate milestones achieved at what age: crawling \_\_\_\_\_ walking \_\_\_\_\_ talking \_\_\_\_\_

Significant Illnesses/Injuries \_\_\_\_\_

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Emotional problems can be passed on in families either genetically or historically. Is there a history of medical or psychological/psychiatric problems for:

Father \_\_\_\_\_

Mother \_\_\_\_\_

Sisters or Brothers \_\_\_\_\_

Grandparents \_\_\_\_\_

Extended Family \_\_\_\_\_

Suicidal and/or homicidal ideations \_\_\_\_\_

**TREATMENT INFORMATION**

**Child/Adolescent**

Please list the reasons that brought you and your youth to therapy \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Parent**

Please list the reasons that brought you and your youth to therapy \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has there been previous counseling or other professional contact for these or other concerns?  
\_\_\_\_\_  
\_\_\_\_\_

Has there been previous counseling or other professional contact for these or other concerns?  
\_\_\_\_\_  
\_\_\_\_\_

**Parent**

Is there any individual(s) who you think may want to confer with you therapist during the course of your child/adolescent's therapy? (eg. doctor, lawyer, teacher, parent)  
\_\_\_\_\_  
\_\_\_\_\_

Is there or has there been a custody dispute over this youth? \_\_\_\_\_ Yes \_\_\_\_\_ No

What is the present custody arrangement for this youth? \_\_\_\_\_

**RELIGIOUS BACKGROUND**

**Child/Adolescent**

Religious Background \_\_\_\_\_  
Practicing? \_\_\_\_\_

**Parent**

Family's Religious Background \_\_\_\_\_  
Practicing? \_\_\_\_\_  
Church/Religious involvement by the family?  
\_\_\_\_\_  
by the youth? \_\_\_\_\_

CHILD/ADOLESCENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_