2340 E. Trinity Mills Road, #300
Carrollton, TX 75006
(972) 824-0803
shannon.johnsonlpc@gmail.com
www.shannonjohnsonlpc.com

Child/Adolescent Background Information

Date _____Person completing form _____Referred by _____

Child's Name _____ Age _____
Last First Middle Nickname

Date of birth _____ Sex _____ Grade _____

Name of parent child is living with _____ Email address _____

Address _____Home phone _____
Street City State Zip

Employer _____Work Phone _____Cell Phone_____

Name of other biological parent _____

Address _____Home Phone _____
Street City State Zip

Employer _____Work Phone _____Cell Phone _____

Permission to contact you at work? Mom: **Yes/NO** Dad: **Yes/No**

Permission to confirm appointments? **Yes/No** Phone _____

In the event I must cancel the appointment, where should I call? _____

Address to use for correspondence _____

Primary Insurance Carrier

_____

Address _____ Phone_____

Insurance ID# _____ Group/Policy# _____

Name of Insurance Group _____Effective Date of Coverage _____

Insured's Name _____DOB _____ SS#_____

Assignment of Benefits: *"I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of benefits to Shannon L. Johnson, LPC for the services provided."*

_____ _____
Signature *Date*

Emergency Contact _____
(non-family member) Name Home Phone Cell Phone Work Phone

People living in child's home:

Name	Relationship To child	Age	Occupation	Does child get along with this person?

Immediate family members living elsewhere (biological parent, siblings, half/step siblings)

Name	Relationship To child	Age	Occupation	Does child get along with this person?

Child's Health:

Child's Primary Care Physician:
Name:_____Phone:_____

Physical disability or chronic illness? _____

What medication is your child currently taking:

Medication	Dosage	Purpose

What extra-curricular activities is your child involved in?_____

What are your child's responsibilities? _____

Current Concerns:

___Abuse (physical, emotional, sexual)
___Adjustment to life changes
___Bed wetting

___Drug or alcohol use (both legal and illegal drugs)
___Eating problem
___Family or step family relationships
___Feeling angry or irritable
___Feeling anxious
___Feeling sadness or depression
___Gang-related concerns
___Health concerns (physical complaints)
___Academic
___Non-family relationship problems
___Parent-Child relationship
___Sexual concerns
___Sleep problems
___Speech problems
___Suicidal thoughts, statements, or attempts
___Self injury
___Unusual behavior or changes in behavior
___Other _____

Current Family Stressors:

___Chronic illness of family member
___Death of significant person
___Domestic violence
___Domestic emotional abuse
___Family member absent
___Family member disability or major accident
___Family member emotional problems
___Family member suicide
___Financial problems/parent job loss
___Frequent moves/school changes
___Parents arguing frequently
___Parents divorced or separated
___Other _____

Describe your relationship with the child's other biological parent:
_____
_____
Is child adopted? **Yes/No** When? _____
Any serious marital strife leading to separation **Yes/No** Date of separation: _____
Date of Divorce: _____ Length of marriage to child's biological parent: _____
Who has legal authority to seek psychological services? _____
Dates of remarriage: Mom _____ Dad _____ Name of step-parents _____
Describe child's relationship with step mom/dad _____

Willing to participate in child's therapy? Mom: **Yes/No** Dad: **Yes/No**

Has your child ever been treated for psychological, emotional or behavioral concerns? **Yes No**
Please explain if yes: _____

Family History:

History of your child having learning, emotional, or behavioral problems? Yes No

History of your child having alcohol or drug experimentation or abuse? Yes No

History of family violence? Yes No

History of criminal activity in the family? Yes No

School related problems (please explain each):
Academic _____
Discipline_____
Severely teased or bullied _____

What characteristics do you admire about your child?

What is your style of discipline?

What are your goals for therapy?

Additional comments or concerns: