



SHANNON JOHNSON LPC
PSYCHOTHERAPY

(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 _____

- 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 _____
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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 _____
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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:
