STEPPING STONES COUNSELING SERVICES
Child and Adolescent Information Form
(For ages 10 and older)

Please have your child/teen fill out this form and bring with them to their appointment. It will save valuable time by filling this out prior to the appointment. This information will help create a treatment plan tailored to meet their needs. If you have any questions, please leave blank and discuss it with the therapist at your appointment.

Name:_____ Date:_____

Date of Birth: _____ Age: _____

Cell Phone: _____ Home Phone: _____

Address: _____

School/Job: _____

Who do you live with?

Name	Relationship to you	Age

Do you have parents or siblings that don't live with you? No Yes (if so who?)

Name	Relationship to you	Age

Have you ever talked to a counselor before? No Yes (Who?)

_____

Do you have any physical health issues? No Yes (Please list)

_____

_____

Hobbies/Interests_____

_____

_____

Church/Spirituality_____

_____

Please circle any of the following problems that may be troubling you:

family difficulties	destructive	lonely
getting in trouble at school	aggressive	overly shy
poor grades	being teased	messy/disorganized
trouble paying attention	bullying others	bed wetting/soiling
can't focus	problem making/keeping friends	sibling rivalry
anxious/worries too much	poor motivation	impulsive
trouble following directions	difficult to control	quick temper
Running away from home	fire setting	drug or alcohol use
feeling sad	stealing	lying
worry about being overweight	low self-esteem	nightmares
hurting myself	trouble going to sleep	sexuality

Other issues that are concerning you: _____

There are some things you may not want to write No Yes