# SONYA L. FONTAINE LPC, PLLC
## CHILD/ADOLESCENT INFORMATION QUESTIONNAIRE

**Date:** ______________________________

Child's Name: ______________________________________________ SS#________________ Sex: ☐ Male ☐Female
First Initial Last

Age:______ Date of Birth:____________ School Attended ________________________________________________ Grade: ________

Biological Parents are: ☐Married ☐Remarried ☐Separated ☐Divorced ☐Widowed ☐Single

Who is Legal Guardian of Child?: ______________________________________________ Phone Number: ______________________

Who does Child primarily live with?: ____________________________________________ Phone Number: ______________________

Address: ____________________________________________________________________________________________
Street Apt # City State Zip

Parent: ____________________________________ SS#_______________ ☐Mother ☐Father Date of Birth:___________
First Initial Last

Parent: ____________________________________ SS#_______________ ☐Mother ☐Father ☐Step Parent Date of Birth:___________
First Initial Last

Address: ____________________________________________________________________________________________
Street Apt # City State Zip

Telephone Number: Home (_____) __________________ Work (_____) __________________ Cell (_____) __________________

E-mail: _______________________ Permission to contact by email: ☐Yes ☐No Permission to leave a message on your cell phone: ☐Yes ☐No

Do you attend a church: ☐Yes ☐No Church Attended _____________________________ Member: ☐Yes ☐No How regularly _________

Marital Status (Check one): ☐Single ☐Married ☐Remarried ☐Separated ☐Divorced ☐Widowed

Mother Employer: _____________________________ Occupation: __________________ Employer Phone: (____) _______________

Highest Level of Education: ☐Grade School ☐High School ☐Technical Degree ☐Bachelor's Degree ☐Master's Degree ☐Advanced Degree

Father Employer: _____________________________ Occupation: __________________ Employer Phone: (____) _______________

Highest Level of Education: ☐Grade School ☐High School ☐Technical Degree ☐Bachelor's Degree ☐Master's Degree ☐Advanced Degree

Non-custodial Parent – Complete This Section If Applicable

Parent's Name: ______________________________________ SS#___________ ☐Mother ☐Father Age:_____ Date of Birth:________
First Initial Last

Address: ____________________________________________________________________________________________
Street Apt # City State Zip

Telephone Number: Home (_____) __________________ Work (_____) __________________ Cell (_____) __________________

E-mail: ________________________________________ Permission to contact by email: ☐Yes ☐No

Attend a church: ☐Yes ☐No Church Attended ____________________________________ Member: ☐Yes ☐No How regularly _________

Marital Status (Check one): ☐Single ☐Married ☐Remarried ☐Separated ☐Divorced ☐Widowed

Employer: _______________________________ Occupation: ____________________ Employer Phone: (____) _________________

Permission to contact: ☐Yes ☐No

Highest Level of Education: ☐Grade School ☐High School ☐Technical Degree ☐Bachelor's Degree ☐Master's Degree ☐Advanced Degree

List the members of your family and all others currently living in your home:

Name ______________________ Age ________ Relationship ______________________

Name ______________________ Age ________ Relationship ______________________

Name ______________________ Age ________ Relationship ______________________

Source of Referral: ☐Friend ______________________ ☐Physician ______________________

☐Minister/Church ______________________ ☐Other(List) ______________________

Has child ever consulted a professional counselor or psychiatrist?: ☐Yes ☐No Hospitalized: ☐Yes ☐No

Date ____________ Problem Addressed ______________ Counselor ______________________

Date ____________ Problem Addressed ______________ Counselor ______________________

Health information:
Primary Care Physician: ______________________ Phone: ____________ Last Visit: __________

1. What medications are you currently taking and the reason:

______________________________________________________________________

2. Please list any surgeries or major illnesses you have had:

______________________________________________________________________

3. Do you have a history or are currently experiencing of any of the following: (circle all that apply)
*Please mark an "X" to the left if any immediate family members have experienced any of these things :*

| | | | |
|---|---|---|---|
| Depression/Sadness | Learning disability | ADHD | Witness to spousal abuse |
| Decreased ability to sleep | Anger outbursts | Death of a parent | Hyperactivity |
| Decreased appetite | Mood swings | Death of a sibling | Pornography |
| Increased appetite | Physical abuse | Forgetfulness | Hearing voices others cannot hear |
| Increase in sleeping | Sexual abuse | Divorce in family | Same sex attraction |
| Anxiety/Worry | Emotional abuse | Separation with spouse | Seeing things others cannot |
| Panic attacks | Addiction to alcohol or drugs | Irritability | Nightmares |
| Unrealistic fears | Distractibility | Crying Spells | Bed Wetting |
| Poor grades | ADD | Obsessive-compulsive behaviors | Addiction (other) __________ |

Suicidal Thoughts: ☐current ☐past frequency: _____ when: _________ Suicide Attempt – date: ___________ Hospitalized ☐Yes ☐No

Briefly describe your reason for seeking therapy?

______________________________________________________________________

What have you attempted to do to treat this problem? What has worked and has not worked?

______________________________________________________________________

______________________________________________________________________

How will you know when therapy has been successful?

______________________________________________________________________

______________________________________________________________________

Please provide any additional information, which you feel pertinent for therapy?

______________________________________________________________________

______________________________________________________________________

Would you like Sonya to pray with you in session? Circle one: ☐Yes ☐No

Our goal is to best meet your emotional needs in a confidential, respectful and God-centered way.
Please feel free to discuss this or any other issue with us.
Sonya L. Fontaine L.P.C., PLLC