Diane Gans, MA, LLC
Psychological Counseling and School Consultation
1609 Willamette Falls Drive
West Linn, OR 97068
(503) 704-3759

Child/Adolescent Information Form

Name: _________________________________ Today's Date ____________

Date of Birth: _________________________

Home Address: ____

City: _____________________ State: _________________ Zip: _________

Phone: __________________________ Work/Cell Phone: _____________________

E-mail Address: ___________________________________

Preferred means of communication (please circle) Phone Email

Name(s), age(s), and relationship(s) to client of those living in the home:

Please describe what brings you to counseling at this time?

What have you already tried to manage the difficulties?

Please list and describe your child's character strengths and sources of enjoyment (include hobbies/friendships/interests)

Please note any developmental issues in the following areas. Include both areas of struggle and strength in the areas of physical needs (sleeping, eating), emotional expression, and socialization:

Pregnancy/Infancy

Toddler/Preschool

Elementary School:

Middle School:

Please list any significant medical problem for which your child has been treated in the past, as well as any past or current medications.