COLLABORATIVE COUNSELING CENTER
Working together to inspire change and promote growth

5560 Sterrett Place, Suite 201
Columbia, MD, 21044
p. (443) 546-4000
f. (443) 546-4005

www.collaborativecounselingcenter.com

Clinical Information Form

To be completed by parent/guardian for client's aged 17 and under

Person(s) Completing the Form: _____Relationship to Patient: _____

Why are you seeking help at this time?

_____

_____

_____

_____

_____

Current mental health concerns:

_____

_____

_____

What are your goals for the current treatment/evaluation?

_____

_____

_____

Mental Health History

Past mental health treatment:
For example, outpatient therapy, medication management, residential or inpatient treatment, TMS, etc.

_____

_____

_____

Past assessments:
(*Learning/academic/IQ, Psychiatric, Psychological, Developmental, Physical, Neuropsychological, Occupational, Speech & language, Audiology, Neurological (e.g., MRI, CAT scan, EEG, etc.), other) IF APPLICABLE, PLEASE BRING PRIOR REPORT(S) TO YOUR APPOINTMENT)*

_____

_____

_____

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Past mental health diagnoses: _____

Diagnoses and approximate date/age diagnosed: _____

Has the patient ever been prescribed medication for psychiatric treatment? Yes No

Is the patient currently being prescribed medication for psychiatric treatment? Yes No

If YES to either above, please fill out below to the best of your knowledge:
Include medication name, dose, start/end dates, side effects (if applicable) and reasons for stopping (if applicable)

_____

_____

_____

Medical History

Primary Care/Pediatrician Name: _____

Office Name: _____ Office Phone Number: _____

Please list any current medications and previous medications (include prescription and over-the-counter), excluding psychiatric medications:
Please include medication name, dose, length of treatment, start/end date, side effects (if applicable) and reason for stopping the medication.

_____

_____

_____

Please list and describe any current or past medical diagnoses or conditions:

_____

_____

Does the patient have any allergies? Yes No

If YES, please elaborate (what patient is allergic to and reactions):

_____

_____

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Family History

Please list the name(s) of the people who live in the house with the patient.
Please include, name, relationship to child, gender, age and grade/job

_____

_____

Parental Marital Status: _____

If the patient's parents are separated or divorced, what are the current custody and visitation arrangements?
CCC may ask for copies of legal documentation of parental rights and require consent for treatment.

_____

_____

Was the patient adopted? Yes No

If YES, please elaborate:
Please include, age of child was at adoption, country of adoption (if applicable), relationship with birth family, pre-adoption environment, circumstances of the adoption, and anything else you may find pertinent.

_____

_____

_____

_____

Educational History

Please list all schools that the child has attended (NOT including the current school):
Please include school name, grade(s) completed, year(s) attended and reason for switching.

_____

_____

How does the patient perform in school academically? _____

Does the patient receive accommodation or additional supports at school? Yes No

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If YES, please include type of service or accommodation (504, IEP, speech, counseling, OT, tutoring, etc.) and start/end dates of services (if applicable): CCC may ask for copies of documentation.

Social History

Please describe the patient's overall current social skills and peer relationships:

Does the child have a history of being bullied/teased? If yes, please describe:

Please describe how the patient generally spends her/his free time (e.g., plays alone, plays with friends, plays sports, watches TV, and plays video games):

What extracurricular activities, sports, and/or other special interests does the patient engage in (inside or outside of school)? Also, please describe how well you feel the child does in these areas:

To your knowledge, has the patient ever used any of the following (check all that apply):

☐Caffeine (frequent use only; in any form - including cola drinks)
☐Tobacco/Nicotine (in any form)
☐Alcohol
☐Prescription medication(s) misuse
☐Recreational drug(s) (including marijuana)
☐Other: _____
_____

If yes to any, please list types and briefly describe the patient's use of each, including frequency/amount, if the use is suspected/confirmed and if use is in the past or current:

Has the patient ever had any police contact or legal problems? If yes, please describe:

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Please note any important information regarding current or past trauma/stressors in the patient's life and approximate dates that the events occurred:

Please share patient strengths and any other pertinent information not previously asked: