Dawn Stremel, MA, LMFT
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CHILD/YOUTH QUESTIONNAIRE **Today's Date:** _____

Youth's name: _____ Age: _____ Birth Date: _____

Youth's residential address: _____ City: _____ Zip: _____

Home phone: _____ (Is it okay to leave a message at this number? _____)

Youth's cell number: _____

(Okay to text/leave messages at this number? _____)

Custody/Parenting Plan? (Please describe & provide copy of plan): _____

_____

Other children in the home (names and ages): _____

_____

Any other siblings not in home: _____

Referred for services by: _____

PARENT/GUARDIAN INFO

Parent/Guardian Employer(s): _____

_____

Home phone: _____Is it okay to leave a message at this number? _____

Work phone(s): _____Is it okay to leave a message at these numbers? _____

Cell phone(s): _____ Is it okay to text/leave a message at these numbers? _____

Insurance (Name, Group #, Individual # etc.): _____

Deductible amount? _____ Co-Pay/Co-Insurance amount? _____

Emergency contact person(s): _____

Relationship to youth/parent: _____ Phone numbers: _____

Youth's school: _____ Current Grade: _____

Educational or learning concerns? _____

_____

Extracurricular sports and activities? _____

_____

Youth's Physician: _____ Phone Number: _____

Last physical/visit to the doctor: _____

Current health concerns, problems, disabilities, etc.: _____

_____

_____

_____

Current medications, including doses, & dosing directions: _____

_____

_____

_____

Previous Counseling or Psychotherapy for youth:

Mental Health Hospitalizations:

Drug/Alcohol Use:

Inpatient/Outpatient Treatment:

General Hospitalizations:

Why are you seeking therapy services at this time/ what are your goals for seeking treatment at this time? (Please continue on back of page, if necessary)