



Lighthouse Family Counseling

Safety, Hope, and Guidance

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CHILD INFORMATION FORM

Name _____ Date of 1st Appointment _____ Therapist _____
Date of Birth _____ Age _____ Gender: Male _____ Female _____

MEDICAL HISTORY

Name of Primary Care Physician: _____

Physician's Address: _____ Physician's Phone: _____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer: _____

Date of last medical evaluation: _____ Date of next appointment: _____

Current medications being taken:

- 1) _____ Dosage/Freq _____ Start Date _____ Purpose _____
- 2) _____ Dosage/Freq _____ Start Date _____ Purpose _____
- 3) _____ Dosage/Freq _____ Start Date _____ Purpose _____
- 4) _____ Dosage/Freq _____ Start Date _____ Purpose _____

Prescribed by: _____

Has your child ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any important medical history, chronic ailments, or other health problems your child experiences: _____

Describe any other health problems or important medical history about your child's immediate family members and close relatives, including chronic ailments: _____

Does your child have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: _____

SCHOOL HISTORY

Does your child experience any developmental, academic or behavior problems while in school or daycare, with peers or teachers? (Circle One) YES NO If yes, please explain: _____

What was the last year of school your child completed? _____

What school is he/she attending? _____ Is your child home-schooled? (Circle One) YES NO

Please check all information which applies to your child's biological parents:

MOTHER	<input type="checkbox"/> living	FATHER	<input type="checkbox"/> living
	<input type="checkbox"/> deceased		<input type="checkbox"/> deceased
	<input type="checkbox"/> married		<input type="checkbox"/> married
	<input type="checkbox"/> divorced		<input type="checkbox"/> divorced
	<input type="checkbox"/> remarried _____ # of times		<input type="checkbox"/> remarried _____ # of times

With whom does your child live: _____

What custody and/or visitation orders are in place? : _____

*** Please copy orders to be placed in client's file.**

Does your child consider anyone else to be a "parent" in his/her life? YES NO If so, whom?_ _____

Describe your relationship with your child:

Currently: _____

In the past: _____

Describe your child's relationship with his/her other parent:

Currently: _____

In the past: _____

List first names and ages of your child's brothers & sisters:

Name	Age	Relationship (biological, step, half, etc.)	Lives with:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe any problems which occurred in your child's family relating to:

Alcohol/drug abuse: _____

Sexual/physical/emotional abuse: _____

Others living in the home with your child:

Name	Age	Relationship	Grade/Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MENTAL STATUS

Please check any of the following that describe how you believe your child has been feeling lately:

sad anxious depressed frightened guilty angry ashamed aggressive resentful
 worthless tearful irritable confused extreme ups/downs jealous hopeless helpless

Describe any behaviors your child has demonstrated that cause concern: _____

Has your child had any change in sleeping habits? (Circle One) YES NO Describe: _____

Has your child had any change in eating habits? (Circle One) YES NO

Describe: _____

Has your child ever considered suicide in connection with his/her **current** problem? (Circle One) YES NO

If so, please give a brief description with dates: _____

Has your child ever **considered suicide** in the **past**? (Circle One) YES NO

Has your child **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: _____

Has your child tried to hurt others or animals recently or in the past? (Circle One) YES NO

If yes, please explain: _____

LEVEL OF FUNCTIONING

Please describe what activities your child participates in: _____

Who is in your child's support network? _____

Please describe your child's level of physical activity: _____

How much time does your child play on the computer, watch TV, or play video games: _____

Is there any other information regarding your child that you would like to share with your child's Therapist that is not covered on this form? You may also use this space to complete earlier responses.

Please list your therapy goals for your child:

THANK YOU!