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**Child Information**

Please complete a separate form for each child involved in the proceedings

Information supplied by: \_\_\_\_\_ Relationship \_\_\_\_\_

Today's Date: \_\_\_\_\_

**I. Personal History**

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_M\_\_\_ F

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Eye color: \_\_\_\_\_ Hair color: \_\_\_\_\_ Race: \_\_\_\_\_

Address: \_\_\_\_\_  
Street & Number City State Zip

Home Phone: \_\_\_\_\_ School Attended: \_\_\_\_\_ Year in School: \_\_\_\_\_

Has the child been involved in previous counseling? : \_\_\_ Yes \_\_\_ No

In your own words, please describe this child, his or her personality and his or her likes and dislikes:

If the parents separated during the child's recollection, please describe any changes in the child's personality that occurred after the separation. If there was never a separation or the child was too young to remember it, just write N/A.

How does this child perform in school?

What is his or her favorite subject? Least favorite?

When was the last parent-teacher conference that you attended and what was discussed?

Does this child have a learning disability of any kind? If so, please describe.

II. Developmental History

Briefly describe any problems in the child's mother's pregnancy and/or childbirth:

Briefly describe the child's friendships:

Briefly describe the child's hobbies and interests:

Describe how the child is disciplined:

III. Medical History

Primary Physician: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Please list any major illnesses and/or surgeries the child has had:

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Please list any current medical concerns:

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IV. Mental Health History

Current Therapist: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Dates first and last seen by this therapist:

Issue for which the child is being seen:

Have you attended sessions with this therapist and if so, how often have you attended sessions?

Please list any medications prescribed to the child for mood, attention, emotional regulation, anxiety, depression, et cetera:

Current:

Past:

Please list any previous mental health services the child has received:

Previous Therapist: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address (optional): \_\_\_\_\_

\_\_\_\_\_

Date last seen by this therapist:

Issue for which the child was seen:

Previous Therapist: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address (optional): \_\_\_\_\_

\_\_\_\_\_

Issue for which the child was seen:

If there are other previous therapists, please provide the relevant information below:.