Client Information (Child)

Parent, please complete all applicable information. Thank you!

Today's Date: _______________ Name of primary client: _______________________________________

Address of primary client: ____

Date of birth of primary client: _________________ Age of primary client: ________ Grade: ______

School of primary client: ___________________________ Teacher (if applicable): _________________

Current weight: _________ Current height: ________

Contact information for parent(s) or guardian(s):

1. Name: _______________________________________ Email: ________________________________

Phones: H: _________________________ W: ________________________ cell: _____________________

Address: ____

Years of Education: ___________ Employer/Job title ____

2. Name: _______________________________________ Email: ________________________________

Phones: H: _________________________ W: _______________________ cell: ______________________

Address: ____

Years of Education: ___________ Employer/Job title ____

May we contact you and leave a message by**:** Email Yes ☐ No ☐ Phone Yes ☐ No ☐

Please indicate which phone: Home ☐ Cell ☐ Work ☐

In case of emergency, please list three contacts:

1. Name: ____ Relationship:______________________________________

   Address: ____ Phone: _______________________________________

2. Name: ____ Relationship:______________________________________

   Address: ____ Phone: ______________________________________

3. Name: ____ Relationship:______________________________________

   Address: ____ Phone: _______________________________________

How did you find out about our services? ____

Insurance Provider: ____________________________ Primary Policyholder: ________________________

Group #:_____________________________________ Policy #:____________________________________

May we contact your child's primary care physician? Yes ☐ No ☐

Physician Name: ____

Address: ____Phone: __________________

List name, age & relationship (to child) of people living in your child's home:

	Name	Age	Gender	Relationship
1.				
2.				
3.				
4.				
5.				
6.				

If child resides in or visits another home regularly (parent, grandparent, other guardian), please list name, age, gender & relationship (to child) of people living in the home:

	Name	Age	Gender	Relationship
1.				
2.				
3.				
4.				
5.				
6.				

If child has other siblings (include half & step siblings) not listed above, please list:

	Name	Age	Gender
1.			
2.			
3.			
4.			

Significant Life Events in the Last Two Years:

- □ Death of a loved one
- □ Move/School change
- □ Financial problems for the family
- □ Parental remarriage/ new step-siblings
- □ Divorce/separation
- □ Medical problems for any family member
- □ Legal problems for the family (assault, DUI, etc)
- □ Family conflict (marital or otherwise)
- □ Birth of a new sibling
- □ Trauma (violence, abuse, natural disaster, car accident or witness to traumatic event, etc)
- □ Other ____

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Child's Strengths and Abilities:

□ Academics/grades
□ Group involvement (clubs, organizations)
□ Sense of humor
□ Care for others
□ Sports
□ Creative (art or music, etc)
□ Religious involvement
□ Gets along easily with others

Other: ____

Current Concerns about Your Child:

□ Behavior at home
□ Suicidal thoughts
□ Sexual behavior
□ Anger/irritability
□ Family relationships
□ Sensitive to touch, sound, light, motion
□Behavior at school
□ Academic performance/grades
□ Eating
□ Peer relationships
□ Frequent worries/shyness
□ Difficulty paying attention
□ Drugs/alcohol
□ Sleeping
□ Fears
□ Health
□ Mood
□ Appears sad

Comments/other: ____

Is there a history of any previous treatment or any evaluations? □ Yes □ No

If so, when and by whom?

□ Educational evaluation: ____
□ Psychological/psychiatric evaluation: ____
□ Outpatient therapy: ____
□ Hospitalization(s): ____

Has your child?

□ Repeated a grade
□ Stopped doing homework
□ Received an IEP or 504 plan
□ Skipped school
□ Been bullied by others
□ Been aggressive at school
□ Been suspended
□ Been expelled
□ Received any special services (OT, PT, Speech, etc.) for: _______________________________________

Does your child take medication? □ Yes □ No

If so, please list diagnosis, medication(s) and dosage(s):____

Prescribing physician____

Child's Medical History: Weight at birth: ____________

□ Medical problems during pregnancy
□ Maternal drug or alcohol use during pregnancy
□ Premature birth (if so, weight at birth: _____________ gestational age: __________)
□ Complications during birth (ex. Emergency C-section, low oxygen, etc)
□ Stayed in neonatal intensive care (if so, how long? ______________________)
□ Frequent ear infections
□ Asthma or allergies
□ Head injuries/concussions/seizures/fevers over 104 degrees
□ Serious accidents/hospitalizations
□ Surgeries
□ Problems with eating or sleeping

Comments/other: ____

Child's Developmental History:

Problems (current or past) with:

□ Sitting up
□ Writing letters or using scissors
□ Physical coordination
□ Fears/worries
□ Walking
□ Talking
□ Bedwetting
□ Toileting
□ Anger/temper tantrums
□ Reading or letter identification
□ Sexual play
□ Hyperactivity
□ Responding to discipline or behavior management

Comments/other: ____

Child's Social Relationships:

Does your child have a friend or friends outside the family? □ Yes □ No

Do you know them? □ Yes □ No

Do his/her friends tend to be: □ older □ younger □ about the same age as your child

How well does your child get along with others?

Comments: ____

Family History:

Has anyone in your family struggled with (treated or untreated, past or present):

□ Depression or Bipolar Disorder
□ Anxiety
□ Learning problems (reading, math, spelling)
□ Attention problems
□ Excessive alcohol or drug use
□ Sexual abuse
□ Physical abuse
□ Suicide attempts or completed suicide
□ High conflict among family members

The reason for today's visit is: ____

____

Do you have any other concerns? ____

____

How would you like things to improve as a result of treatment? ______________________________

____

I authorize the above information to be accurate and completed to the best of my knowledge.

____
Print Name

____ __________________
Signature Date