CLIENT INFORMATION FORM – CHILD

This form is confidential

Today's Date: _____

Your Child's Name: _____
LAST FIRST MIDDLE INITIAL

Parent/Legal Guardian's Name: _____
LAST FIRST MIDDLE INITIAL

Child's Date of Birth: _____ Gender: ❑ M ❑ F

Parent/Legal Guardian's Social Security #: _____

Home Street Address: _____

City: _____ State: _____ Zip: _____

Parent/Legal Guardian's Name of Employer: _____

Address of Employer: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Calls will be discreet, but please indicate any restrictions: _____

_____

Referred by: _____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No

If referred by another clinician, would you like for us to communicate with one another? ❑ Yes ❑ No

Person(s) to notify in case of any emergency: _____
NAME PHONE

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so:

(Your Signature): _____

Please briefly describe your child's presenting concern(s): _____

_____

_____

_____

What are your/your child's goals for therapy? _____

_____

_____

How long do you/your child expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

_____

The following information will help guide your treatment. Please try to fill out as much as you are comfortable disclosing.

MEDICAL HISTORY

Please explain any significant medical problems, symptoms, or illnesses your child has had: _____

_____

_____

_____

Current Medications: *(if you need more room, please write on the back of this page)*

NAME OF MEDICATION	DOSAGE	PURPOSE	NAME OF PRESCRIBING DOCTOR

Previous medical hospitalizations (Approximate dates and reasons): _____

_____

_____

Previous psychiatric hospitalizations (Approximate dates and reasons): _____

_____

_____

Has your child ever talked with a psychiatrist, psychologist, or other mental health professional? ❑ YES ❑ NO

(Please list approximate dates and reasons): _____

_____

_____

Sexual/Gender Identity:
❑ Heterosexual ❑ Lesbian ❑ Gay ❑ Bisexual
❑ Transgender ❑ Asexual ❑ In Question ❑ Other

Racial/Ethnic Identity:
❑ African/African-American/Black
❑ Bi-Racial/Multi-Racial
❑ Middle Eastern/Middle Eastern-American
❑ White/European-American
❑ Latino/Latino-American
❑ American Indian/Alaska Native
❑ Asian/Asian-American/Asian Pacific Islander
❑ Not listed

FAMILY

How would you describe your child's relationship with his/her mother? _____

_____

_____

How would you describe your child's relationship with his/her father? _____

_____

_____

Are the child's parents still married? ❑ Yes ❑ No
If divorced, how old was the child when the parents separated or divorced, and how do you think this impact him/her? _____

_____

_____

How would you describe your child's relationship with his/her grandparents? _____

_____

_____

Were there any other primary care givers who have had a significant relationship with your child?
If so, please describe how these people may have impacted your child's life: _____

_____

How many sisters does your child have? _____ Ages? _____

How many brothers does your child have? _____ Ages? _____

How would you describe your child's relationships with his/her siblings? _____

_____

_____

SOCIAL SUPPORT, SELF-CARE & EDUCATION

Child's current level of satisfaction with friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

How would you describe your child's relationships with his/her peers? _____

_____

_____

Please briefly describe any history of abuse, neglect and/or trauma: _____

_____

_____

Please briefly describe your child's self-care and coping skills: _____

_____

_____

What are your child's diet, weight, and exercise/activity patterns? _____

_____

_____

Please briefly describe your child's school performance and experience: _____

_____

_____

What are your child's hobbies, talents and strengths? _____

_____

_____

GRADE LEVEL

❑ Nursery School	❑ Pre-K	❑ Kindergarten	❑ 1st Grade	❑ 2nd Grade
❑ 3rd Grade	❑ 4th Grade	❑ 5th Grade	❑ 6th Grade	❑ 7th Grade
❑ 8th Grade	❑ 9th Grade	❑ 10th Grade	❑ 11th Grade	❑ 12th Grade

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD & CIRCLE THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Depression			Parents Divorced			Stomach Aches		
Mood Changes			Seizures			Fainting		
Anger or Temper			Cries Easily			Dizziness		
Panic			Problems with Friend(s)			Diarrhea		
Fears			Problems in School			Shortness of Breath		
Irritability			Chest Pain			Concentration		
Fighting with Siblings			Lump in the Throat			Headaches		
Issues Re: Divorce			Sweating			Loss of Memory		
Sexually Acting Out			Heart Problems			Excessive Worry		
History of Child Abuse			Muscle Tension			Wetting the Bed		
History of Sexual Abuse			Bruises Easily			Trusting Others		
Domestic Violence			Allergies			Fidgets Frequently		
Communicating with Others			Thoughts of Hurting Someone Else			Often Makes Careless Mistakes		
Separation Anxiety			Thoughts of Hurting Self			Impulsive		
Alcohol/Drugs			Thoughts of Suicide			Difficulty Waiting Their Turn		
Drinks Caffeine			Sleeping Too Much			Difficulty Completing Tasks		
Frequent Vomiting			Sleeping Too Little			Difficulty Paying Attention		
Eating Problems			Getting to Sleep			Easily Distracted by Noises		
Severe Weight Gain			Waking Too Early			Hyperactivity		
Severe Weight Loss			Nightmares			Chills or Hot Flashes		
Head Injury			Sleeping Alone					

FAMILY HISTORY OF *(check all that apply):*

❑ Drug/Alcohol Problems	❑ Physical Abuse	❑ Depression
❑ Legal Trouble	❑ Sexual Abuse	❑ Anxiety
❑ Domestic Violence	❑ Hyperactivity	❑ Psychiatric Hospitalization
❑ Suicide	❑ Learning Disabilities	❑ "Nervous Breakdown"

Any additional information you would like to include: _____

_____

_____

_____

_____

_____