CHILD INFORMATION FORM

CONTACT INFORMATION

Today's date: _____

Child/Adolescent complete name: _____Date of birth: _____ Grade: _____
Nicknames or aliases: _____ Age: _____ Social Security #_____-____-_____
Home street address: _____ Apt.:_____
City: _____ State: _____Zip: _____

Mother's name: _____
Cell phone: (____)_____ Home/evening phone: (____)_____ Work phone:
(____)_____ Calls will be discreet, but please indicate any restrictions:_____

Father's name: _____
Cell phone: (____)_____ Home/evening phone: (____)_____ Work phone:
(____)_____ Calls will be discreet, but please indicate any restrictions:_____

Who is the child's Legal Guardian?: _____

Child's School: _____ Pediatrician's Name: _____

School Address: _____ Pediatrician Address: _____

_____ _____

School Phone#: ( ) _____ Pediatrician Phone#: ( ) _____

School Fax#: ( ) _____ Pediatrician Fax#: ( ) _____

Primary Teacher:_____

Guidance Counselor: _____

REASONS FOR SEEKING TREATMENT AT THIS TIME?

_____

_____

_____

Child/Adolescent's symptoms include (check all that apply):

☐Inattention ☐Hyperactivity ☐Depression ☐Anxiety ☐Insomnia ☐Sadness ☐Crying Spells

☐ Impulsive ☐Suicidal Thoughts ☐No Pleasure/joy ☐Low energy ☐Substance abuse ☐Pain ☐ Can't sit still

☐Can't concentrate ☐Eating too little ☐Eating too much ☐Sleeps too much ☐Sleeps too little ☐Mood Swings

☐Worries too much ☐Weight Loss ☐Weight Gain ☐Distrustful ☐Self-harm ☐Steals ☐Lies ☐Fearful

☐Explosive Outbursts ☐Oppositional Behaviors ☐Difficulty with change/transitions ☐School/learning difficulties

☐Fighting ☐Obsessive/compulsive ☐Thoughts to harm others

Other Symptoms/Behaviors: _____
_____
_____

How long have these difficulties been present?
_____

What are your goals for treatment? _____
_____

WHOM MAY WE THANK FOR THIS REFERRAL?

Name: _____ Phone: _____

☐ Internet website (which?): _____ ☐ Seminar _____ ☐ Other: _____

MENTAL HEALTH HISTORY

Previous Mental Health Treatment:

Date(s)	Therapist/Facility	Reason for seeking treatment	Was treatment helpful?

Previous Psychological and/or Educational Testing

Date(s)	Assessor/Facility	Reason for seeking testing	Results of testing?

Is the child currently prescribed any psychiatric medications?

Date(s)	Medication	Reason for prescription	Is medication helpful?

Has the child been prescribed any psychiatric medications in the past?

Date(s)	Medication	Reason for prescription	Reason stopped

FAMILY INFORMATION

Mother		Father	
Name:		Name:	
Date of Birth / Age		Date of Birth / Age	
Education		Education	
Employer		Employer	
Occupation		Occupation	
Marital Status		Marital Status	
Length of Marriage		Length of Marriage	

If parents are divorced, what is the custody arrangement?_____

If parents are divorced, has either parent remarried? ☐ Yes ☐ No

Do both parents agree to this treatment/evaluation? ☐ Yes ☐ No (If not, please explain): _____

_____

Please list the child's siblings:

Name	Age	Sex	Living at home?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Is there anyone else living at home?:_____

Family Relationships:

What is your child's relationship like with:

Mother: _____ Father: _____

Sister (s): _____ Brother (s): _____

Step-parent (s), if applicable: _____

Parent's marital relationship: _____

Type of discipline in home: _____

Has your child every experienced any traumatic event (accident, death of a loved one): ☐ No ☐ Yes: If yes, please describe: _____
_____

History of physical or sexual abuse, family violence or neglect?: ☐ No ☐ Yes, If yes, please describe: _____
_____

_____

FAMILY BACKGROUND INFORMATION

History of psychiatric/psychological disorders in family: _____

_____

History of substance abuse in family: _____

History of suicide in the family? (if yes, please describe) _____

History of violence in the family: _____

History of sexual abuse in the family: _____

DEVELOPMENTAL HISTORY

Please fill in any information you have on the areas listed below.

1. PREGNANCY AND DELIVERY

Prenatal medical illnesses and health care: _____
_____

Mother's age when child was born: _____Was the child premature? ☐ ☒No Yes Birth weight: _____

Any birth complications or problems? _____
_____

2. FIRST FEW MONTHS OF LIFE

Any medical conditions/allergies? _____

Sleep patterns or problems: _____
_____

Child's personality as a baby: _____
_____

3. MILESTONES: At what age did your child do the following?
Sat up: _____ Crawled:_____Walked: _____ Toilet Trained: _____
First Word:_____ Talked in sentence: _____
Any current bedwetting/toileting concerns?: _____
Any speech, hearing, or language difficulties? _____
_____
Child's primary language at home: _____ Other language(s) spoken: _____

MEDICAL HISTORY

Date of child's last physical exam: _____

At any time has your child had the following?

Condition	NO	YES	If yes, please describe:
Asthma	☐	☐	
Allergies	☐	☐	
Diabetes	☐	☐	
Epilepsy or seizure disorder	☐	☐	
Heart or blood pressure problems	☐	☐	
Broken bones	☐	☐	
Surgery	☐	☐	
Head injury with loss of consciousness	☐	☐	
Lengthy hospitalization	☐	☐	
Speech or language problems	☐	☐	
Chronic ear infections	☐	☐	
Hearing difficulties	☐	☐	
Vision problems	☐	☐	
Fine motor/handwriting problems	☐	☐	
Gross motor difficulties/clumsiness	☐	☐	
Appetite disturbance	☐	☐	
Sleep problems	☐	☐	
Soiling problems	☐	☐	
Wetting problems	☐	☐	

Other (please describe): _____
Therapist use only: If medical condition, was a referral provided? ☐ N/A ☐ NO ☐ YES: to _____
_____

Current medications (non psychiatric):

Date(s)	Medication	Reason for prescription

ACADEMIC INFORMATION

School(s) (Name, district, address, phone)	Grade(s)	Age	Dates attended
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What kind of grades does your child usually earn?: A B C D F other: _____
Child's scores on most recent standardized test (FCAT, SAT, etc.): _____
Present attitude toward school: _____
Grade(s) repeated: _____ Reason: _____
Does your child have an IEP (Individualized Educational Plan)?: ☐ YES ☐ NO
Placement in special classes?: _____
Describe school behavioral problems: _____
Describe relationship with teachers: _____
Describe relationship with peers: _____
Please list your child's Extracurricular activities: _____
List hobbies, sports; recreational, TV, and toy preferences; etc.: _____
_____

LEGAL HISTORY

Has your child had any type of legal involvement? ☐ No ☐ Yes, If yes, please describe: _____
_____

OTHER

Please list some of your child's strengths: _____
_____

Please list some of your child's weaknesses: _____
_____

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important?
_____
_____
_____

My signature below indicates that I have voluntarily and accurately completed the Form. A photocopy of this agreement will be considered as valid as an original.

Client Name	Signature of Client/Parent or Guardian	Date
Therapist Name	Signature of Therapist	Date