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Child & Family Information

Please fill out this form completely. If there is information that you do not know, or cannot obtain, write in the word "unknown". This information will be treated in a strictly confidential way.

Date completed _____

Child's name: _____ Sex: M F

Date of Birth _____ Age _____

Present address _____
Number Street City State Zip

Home phone _____ Business or cell phone of parent(s) _____

Religious Preference _____

Parent/Guardian's Name _____

Biological or Adopted _____ If adopted, child's age at adoption _____

Child's Ethnic Background _____

Primary Language spoken in the home _____

If child is not currently living with both natural parents:

Is either natural parent deceased? ____ If so, when? _____

Were parents married? _____ When? _____

Have parents separated? _____ When? _____

Have parents divorced? _____ When? _____

Other marriages? _____

Briefly explain any special living circumstances (foster-care, custody arrangements, visiting rights, etc.) _____

How long has the child resided at the present address? _____

Does the child share a bedroom with anyone? Y N If yes, with whom? _____

Education

Child's School _____ # Years attended _____ Grade _____

Teacher _____ School Counselor _____

Who referred you to this office? _____

Client Information

Has your child had any counseling or are they currently in any type of counseling? _____

Name, address and phone number of current therapist _____

How successful did you find previous counseling? _____

Is child currently seeing a psychiatrist? Y N

If yes, name, address and phone # of psychiatrist _____

Is child taking any medications? Y N

If yes, what type of medication does child take and what is the medication for?

Does it help? _____

When was child's last physical exam? _____ Given by whom? _____

What were the results? _____

****Counselor: If it has been over a year or if presenting symptoms could possibly be the result of a medical issue, suggest that the parents take child in for a check up**

Presenting Concerns

What is your main concern about your child? _____

How long has this concern existed? _____

In what setting does it occur? (circle all that apply)

Home School Church Sports Neighborhood Public places Other_____

Does this child have any academic concerns? Y N

If yes, please explain _____

Has he/she ever repeated a grade? _____ Which grade? _____

Has there been any abuse of the child? (please circle all that apply)

Physical Verbal Sexual Neglect

Please explain anything that was circled _____

Would this child say that he/she had many friends? Y N

Please explain _____

Would other adults who observe this child say he/she had many friends? Y N

Please explain _____

What are the typical difficulties this child has with brothers and/or sisters? _____

How does the child express anger? _____

Was there a time when the child seemed to be doing well in school and/or home? Y N

Describe _____

What does the child do well? _____

How will you know that things are changing, as the process is ongoing? _____

What do you expect will be different when therapy is completed?

Developmental History

Pregnancy and Delivery:

Length of pregnancy: _____ weeks Birth weight: _____ lbs, _____ oz

Please describe any pregnancy complications: _____

Mother's Drug/Alcohol use during pregnancy? Y N

If yes, please explain: _____

Early Childhood: Check one in each column indicating when child showed development in each area.

CHILD WALKED
___ less than 12 months
___ 12-24 months
___ 24-36 months
___ over 36 months
___ has never walked

CHILD SPOKE WORDS
___ less than 12 months
___ 12-24 months
___ 24-36 months
___ over 36 months
___ has never spoken words

SPOKE SENTENCES
___ less than 12 months
___ 12-24 months
___ 24-36 months
___ over 36 months
___ never spoken sentences

CHILD FIRST TRAINED FOR URINATION
___ less than 12 months
___ 12-24 months
___ 24-36 months
___ 3-5 years
___ over 5 years
___ not yet trained

CHILD FIRST TRAINED FOR BOWELS
___ less than 12 months
___ 12-24 months
___ 24-36 months
___ 3-5 years
___ over 5 years
___ not yet trained

SINCE INITIAL TOILET TRAINING
___ frequent wetting during day
___ frequent wetting during night

SINCE INITIAL TOILET TRAINING
___ frequent soiling during day
___ frequent soiling during night

Explain any of the above: _____

Puberty: Onset of puberty (breast development, menstruation, pubic hair, facial hair)

___ under 10 years
___ 10-12 years
___ 12-14 years

___ 14-16 years
___ over 16 years
___ no development

Illnesses and Diseases: Please check any illness or disease which child has had.

- | | | |
|---|--|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> eczema | <input type="checkbox"/> heart disease | <input type="checkbox"/> meningitis |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> influenza | <input type="checkbox"/> broken bone |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> pneumonia | <input type="checkbox"/> others (write in) |
| <input type="checkbox"/> cancer | <input type="checkbox"/> migraine headaches | _____ |
| <input type="checkbox"/> anemia | <input type="checkbox"/> undescended testicles | _____ |
| <input type="checkbox"/> measles | <input type="checkbox"/> high blood pressure | _____ |
| <input type="checkbox"/> mumps | <input type="checkbox"/> low blood pressure | _____ |
| <input type="checkbox"/> chickenpox | <input type="checkbox"/> sinusitis | _____ |
| <input type="checkbox"/> diphtheria | <input type="checkbox"/> appendicitis | |
| <input type="checkbox"/> scarlet fever | <input type="checkbox"/> heart surgery | |
| <input type="checkbox"/> polio | <input type="checkbox"/> tonsillectomy | |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> convulsions | |
| <input type="checkbox"/> lead poisoning | <input type="checkbox"/> brain injury | |
| <input type="checkbox"/> encephalitis | <input type="checkbox"/> fainting | |

List any medications your child is currently taking:

Hospitalizations: Please list any hospitalizations, age and length of stay.

Condition for which hospitalized

Age
Length of stay

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social & Behavioral: Please check the items the child has difficulty with.

• Auditory	• focus on objects; not people	• physical aggression
• bed wetting	• forgets	• rocking body
• blanking out	• giving up	• shyness
• breath holding	• habits	• sibling conflict
• can't fall asleep	• head banging	• sleep walking
• clumsiness	• hyperactivity	• social isolation
• constipation	• impulsively	• slowness to learn
• coordination	• interrupted sleep	• soiling

• dangerous behavior	• mannerisms	• speech
• daredevil behavior	• nail biting	• stubbornness, rigidity
• diarrhea	• night terrors	• tantrums
• early waking	• nightmares	• thumb sucking
• eating	• verbal aggression	• fears
• vision	• other language	• other (describe)

Family History

Check all of the following family concerns that apply currently or in the last 6 months:

- | | | | |
|--------------------------|-------|----------------------------|-------|
| Marital difficulties | _____ | Older sibling leaving home | _____ |
| Aging grandparents | _____ | Recent death in family | _____ |
| Alcoholism | _____ | Recent death of friend | _____ |
| Serious illness of child | _____ | Drug addiction in family | _____ |
| Serious illness relative | _____ | Financial problems | _____ |
| Birth of a sibling | _____ | Step parent in the home | _____ |
| Move to a new house | _____ | Traumatic experience | _____ |
| Move to a new school | _____ | Other (specify) _____ | |

Has there been anyone in either parent’s family who has been treated for mental illness?

Y N If yes, please explain: _____

Has anyone in either parent’s family been prescribed medication for depression, bipolar disorder, or anxiety?

Y N If yes, please explain: _____

Has anyone in either parent’s family been treated for alcoholism or drugs?

Y N If yes, please explain: _____

Describe briefly any special interests, hobbies and recreational activities in which family members participate:

Child: _____

Mother: _____

Father: _____

Brothers/Sisters: _____

Please list all those living in child's home:

Name	Relationship	Birth date	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all other persons closely involved with child but not living in home:

Name	Relationship	Place of Residence
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe an important family value _____

How would you describe the child as a person? _____

Name of adult completing this form: _____

Relationship to child _____