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CHILD INFORMATION SHEET

The information asked is to help understand you and your child's situation, and to enable me to be of help to you. Please fill out this form as completely as you can.

Referral Source ______________________________ Date __________

Child'sName ____
Last First Middle

Child's Birth date ____________ Age ______ Sex ______

Family Religion ____________________

Father ____

Father's Address ____

Business Name & Address ____

Home Phone ____________________ Work Phone ____________________

Cell Phone ____________________ Email ____________________

Mother ____

Mother'sAddress ____

Business Name & Address ____

Home Phone ____________________ Work Phone ____________________

Cell Phone ____________________ Email ____________________

Date of parent's marriage(s), separation(s), and divorce(s) ____________________

Which parent has the right to seeks counseling and medical care for the child? (If divorced please bring copy of legal documents) (**If divorced, <u>YOU</u> MUST PROVIDE a copy of the MOST RECENT legal documents stating YOU have the ability to CONSENT to psychological care.**) Please sign here confirming that the copy you provided is the most recent order. ______________________________

Child's Address ____

Child's school ______________________________ Grade: __________

School Phone Number ____________________ Teacher: ____________________

School counselor ____________________ Home Schooled ____________________

Height __________ Weight __________ Place of Birth ____________________

PEOPLE CURRENTLY IN HOUSEHOLD INCLUDING CHILD

NAME	RELATIONSHIP TO CHILD	AGE	SEX	EDUCATIONAL LEVEL	OCCUPATION
CHILD					

Any children not living in household?______________________________________

CURRENT LIFE CIRCUMSTANCES

Is the child adopted?_______________Complications during birth or delivery?__________________

Problems with feeding, eating, sleeping?____

Has there been any physical or emotional separations (i.e., death, hospitalizations, depressions) between child and caretaker adult?____

____

Has there, as far as you know been any behavior that can be considered abusive?__________________

____

Previous testing or therapy?____

What, if any, length of time is child on computer or play video games? _________________________

List and concerns about MySpace, FB/other computer related problems: _______________________

Where does the child sleep?____

Is this child sexually active? Details____

Circle all that apply at this time:

Destructive	Overly dependent on parents or siblings
Easily distracted	Reports unusual or peculiar thoughts
Frequently disrupts class	Is always on the go or acts as if “driven by a motor”
Often does not seem to listen	Delinquent (involvement with police)
Excessive fears or worries	Seems to have characteristics of the opposite sex
Runaway behavior	Has difficulty staying seated in school, church, etc.
Lies excessively	Difficult to get his/her attention
Needs lots of supervision	Often speaks or acts before thinking
Sleep problem	Difficulties getting along with other children
Involvement with drug, alcohol	Has difficulty waiting turn in games
Inability to control bowl, bladder	Change in or unusual eating patterns
Difficult to discipline	Overly sensitive (tearful, moody)
Provocative behavior	Socially withdrawn (prefers to be alone)
Argues excessively	Has difficulty in groups, play or school
Stubborn	Seems unhappy or depressed
Bedwetting	May injure self or others
Doesn’t like self	Sexual misbehavior

other____

PRESENT AND PAST HEALTH

Is child currently under a physician's care?________If yes, please give their name(s), phone number and city of practice:____

Has the child ever had invasive medical procedures or surgeries? ______________ If yes, describe: ________

____

Has the child ever or is the child currently taking prescription medication?_________If yes, please list the medications and daily dosages:____

____

Has the child ever or is the child currently seeing a counselor, psychologist, or psychiatrist? _______If so, please give their name(s) and phone number____

____

Listed below are a variety of psychological, medical, and health problems.

1. Place a check mark next to any that your child has ever experienced.
2. Now go back over the items you checked above and **CIRCLE THE CHECK MARKS** for any items that are **CURRENT** patterns or problems in the child's life.

____back problems
____gastritis/ulcers
____alcohol use/abuse
____panic attacks
____hypertension
____kidney problems
____drug use/abuse
____headaches
____suicidal thoughts
____urge to hurt someone
____poor balance
____hearing problems
____sexual problems
____forgetfulness
____dizziness
____chronic anxiety
____skin problems
____AIDS/ARC
____uncontrollable anger
____overeating

_____asthma
_____epilepsy
_____arthritis
_____fainting spells
_____cancer
_____insomnia
_____depression
_____hay fever
_____blackouts
_____trembling
_____eye problems
_____heart problems
_____numbness
_____chronic pain
_____exhaustion
_____nightmares
_____diabetes
_____hopelessness
_____poor appetite

Has the child or his/her family experience any of the following? (Check all that apply)

_______financial problems
_______alcohol/drug problem (parent)
_______alcohol/drug problem (others)
_______major illness/accident (self)
_______major illness/accident (parent)
_______major illness/accident (others)

________legal problems
________divorce
________separation
________marital conflict
________frequent moves
________immigration

Is there anything that has recently happened or is about to happen that represents a major change in the child's life? ____

____

Is there anything else that you think your therapist should know about the child's current life circumstances?____

____