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Finding Strength, Hope and Balance in Difficult Times

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 _____

Child's Name _____
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's Address _____

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) _____

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
AGE SEX

EDUCATIONAL CHILD	OCCUPATION TO CHILD	LEVEL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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? _____

Where does the child sleep? _____

Circle all that apply at this time:

Destructive
Easily distracted
Frequently disrupts class
Often does not seem to listen
Excessive fears or worries
Runaway behavior
Lies excessively
Needs lots of supervision
Sleep problem
Involvement with drug, alcohol
Inability to control bowel, bladder
Difficult to discipline
Provocative behavior
Argues excessively
Stubborn
Bedwetting
Doesn't like self

Overly dependent on parents or siblings
Reports unusual or peculiar thoughts
Is always on the go or acts as if "driven by a motor"
Delinquent (involvement with police)
Seems to have characteristics of the opposite sex
Has difficulty staying seated in school, church, etc.
Difficult to get his/her attention
Often speaks or acts before thinking
Difficulties getting along with other children
Has difficulty waiting turn in games
Change in or unusual eating patterns
Overly sensitive (tearful, moody)
Socially withdrawn (prefers to be alone)
Has difficulty in groups, play or school
Seems unhappy or depressed
May injure self or others
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.

- | | |
|---|--|
| <input type="checkbox"/> back problems | <input type="checkbox"/> asthma |
| <input type="checkbox"/> gastritis/ulcers | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> alcoholism | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> panic attacks | <input type="checkbox"/> fainting spells |
| <input type="checkbox"/> hypertension | <input type="checkbox"/> cancer |
| <input type="checkbox"/> kidney problems | <input type="checkbox"/> insomnia |
| <input type="checkbox"/> drug abuse | <input type="checkbox"/> depression |
| <input type="checkbox"/> headaches | <input type="checkbox"/> hay fever |
| <input type="checkbox"/> suicidal thoughts | <input type="checkbox"/> blackouts |
| <input type="checkbox"/> urge to hurt someone | <input type="checkbox"/> trembling |
| <input type="checkbox"/> poor balance | <input type="checkbox"/> eye problems |
| <input type="checkbox"/> hearing problems | <input type="checkbox"/> heart problems |
| <input type="checkbox"/> sexual problems | <input type="checkbox"/> numbness |
| <input type="checkbox"/> forgetfulness | <input type="checkbox"/> chronic pain |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> exhaustion |
| <input type="checkbox"/> chronic anxiety | <input type="checkbox"/> nightmares |
| <input type="checkbox"/> skin problems | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> AIDS/ARC | <input type="checkbox"/> hopelessness |
| <input type="checkbox"/> uncontrollable anger | <input type="checkbox"/> poor appetite |
| <input type="checkbox"/> overeating | |

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

- | | |
|--|---|
| <input type="checkbox"/> financial problems | <input type="checkbox"/> legal problems |
| <input type="checkbox"/> alcohol/drug problem (parent) | <input type="checkbox"/> divorce |
| <input type="checkbox"/> alcohol/drug problem (others) | <input type="checkbox"/> separation |
| <input type="checkbox"/> major illness/accident (self) | <input type="checkbox"/> marital conflict |
| <input type="checkbox"/> major illness/accident (parent) | <input type="checkbox"/> frequent moves |
| <input type="checkbox"/> major illness/accident (others) | <input type="checkbox"/> 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? _____