

Child Information Form

Today's Date: _____ Completed by: Mother Father Other
Child's Name: _____ Date of Birth: _____
Address: _____
Home Phone: _____

Parent's Name: _____
Address: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____
Years of Education: _____ Occupation: _____

Parent's Name: _____
Address: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____
Years of Education: _____ Occupation: _____

Parents' Relationship Status: Married Never Married Separated
 Divorced Partnered Widowed

If divorced, who is the managing conservator? _____

Siblings (including step-siblings and half-siblings):

Name	Age	Gender
1.		
2.		
3.		
4.		

Others in the home (grandparents, cousins, family friends):

Name	Age	Gender
1.		
2.		
3.		
4.		

Significant Life Events in the Last Two Years

- Death of a loved one
- Move/School change
- Financial problems for the family
- Parental remarriage/ new step-siblings
- Birth of a new sibling
- Trauma (violence, natural disaster, car accident, etc)
- Other _____
- Divorce/Separation
- Medical Problems for any family member
- Legal problems for the family (assault, DUI, etc)

Child's Strengths or Abilities

- Academics/grades Sports Creative (art or music, etc)
- Group involvement (clubs, organizations) Religious involvement
- Sense of humor Care for others

Other: _____

Current Concerns about Your Child

- Behavior at home/school Mood Eating Sleeping
- Suicidal thoughts Academic performance/grades
- Anger/Irritability Difficulty paying attention Peer relationships
- Health Drugs/alcohol Sexual behavior Frequent worries/shyness
- Sensitive to touch, sound, light, motion

Comments: _____

Is there a history of any previous treatment or any evaluations? Yes No

If so, when and by whom?

- Educational evaluation: _____
- Psychological evaluation: _____
- Outpatient therapy: _____
- Hospitalization(s): _____

Does your child take medication? Yes No

If so, please list medication(s) and dosage(s): _____

Who is the prescribing physician? _____

Child's Medical History

- Medical problems during pregnancy
- Maternal drug or alcohol use during pregnancy
- Premature birth (if so, weight at birth: _____ gestational age: _____)
- Complications during birth (ex. Emergency C-section, low oxygen, etc)
- Stayed in neonatal intensive care (if so, how long? _____)
- Health problems as a newborn or toddler
- Frequent ear infections
- Asthma or allergies
- Head injuries/concussions/seizures/fevers over 104 degrees
- Serious accidents/hospitalizations
- Surgeries
- Problems with eating or sleeping

Child's Physician _____

Comments: _____

Child's Developmental History

Problems with...?

- Sitting up Walking Talking Toileting Bedwetting
- Writing letters or using scissors Reading or letter identification
- Physical coordination (running, jumping, climbing)
- Responding to discipline or behavior management
- Anger/temper tantrums Fears Sexual play

Other: _____

Child's Academic History

Current School: _____

School location: _____ Grade: _____

Teacher(s): _____

Has your child...?

- Repeated a grade Skipped school Been suspended Been expelled
- Stopped doing homework Been bullied by others Been aggressive at school
- Received an IEP or 504 plan
- Received any special services (OT, PT, Reading, Speech, Self-Contained, etc)

Child's Social Relationships

Does your child have a friend or friends outside the family? Yes No

Do you know them? Yes No

Do his/her friends tend to be: older younger about the same age as your child

How well does your child get along with others?

Family History

Has anyone in your family struggled with (treated or untreated):

- Depression or Bipolar Disorder
- Anxiety
- Learning problems (reading, math, spelling)
- Attention problems
- Excessive alcohol or drug use
- Sexual abuse
- Physical abuse
- Suicide attempts or completed suicide

Do you have any other concerns about your child?

How did you hear about me and my services?

What do you hope to accomplish by working with me?

