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**CHILD INFORMATION FORM**

Name \_\_\_\_\_ Date of 1<sup>st</sup> Appointment \_\_\_\_\_ Therapist \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

**MEDICAL HISTORY**

Name of Primary Care Physician: \_\_\_\_\_

Physician's Address: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer: \_\_\_\_\_

Date of last medical evaluation: \_\_\_\_\_ Date of next appointment: \_\_\_\_\_

Current medications being taken:

- 1) \_\_\_\_\_ Dosage/Freq \_\_\_\_\_ Start Date \_\_\_\_\_ Purpose \_\_\_\_\_
- 2) \_\_\_\_\_ Dosage/Freq \_\_\_\_\_ Start Date \_\_\_\_\_ Purpose \_\_\_\_\_
- 3) \_\_\_\_\_ Dosage/Freq \_\_\_\_\_ Start Date \_\_\_\_\_ Purpose \_\_\_\_\_
- 4) \_\_\_\_\_ Dosage/Freq \_\_\_\_\_ Start Date \_\_\_\_\_ Purpose \_\_\_\_\_

Prescribed by: \_\_\_\_\_

Has your child ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any important medical history, chronic ailments, or other health problems your child experiences: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Describe any other health problems or important medical history about your child's immediate family members and close relatives, including chronic ailments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Does your child have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SCHOOL HISTORY**

Does your child experience any developmental, academic or behavior problems while in school or daycare, with peers or teachers? (Circle One) YES NO If yes, please explain: \_\_\_\_\_

What was the last year of school your child completed? \_\_\_\_\_

What school is he/she attending? \_\_\_\_\_ Is your child home-schooled? (Circle One) YES NO

Please check all information which applies to your child's biological parents:

MOTHER	<input type="checkbox"/> living	FATHER	<input type="checkbox"/> living
	<input type="checkbox"/> deceased		<input type="checkbox"/> deceased
	<input type="checkbox"/> married		<input type="checkbox"/> married
	<input type="checkbox"/> divorced		<input type="checkbox"/> divorced
	<input type="checkbox"/> remarried _____ # of times		<input type="checkbox"/> remarried _____ # of times

With whom does your child live: \_\_\_\_\_

What custody and/or visitation orders are in place? : \_\_\_\_\_

**\* Please copy orders to be placed in client's file.**

Does your child consider anyone else to be a "parent" in his/her life? YES NO If so, whom?\_ \_\_\_\_\_

Describe your relationship with your child:

Currently: \_\_\_\_\_  
\_\_\_\_\_

In the past: \_\_\_\_\_  
\_\_\_\_\_

Describe your child's relationship with his/her other parent:

Currently: \_\_\_\_\_  
\_\_\_\_\_

In the past: \_\_\_\_\_  
\_\_\_\_\_

List first names and ages of your child's brothers & sisters:

Name	Age	Relationship (biological, step, half, etc.)	Lives with:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe any problems which occurred in your child's family relating to:

Alcohol/drug abuse: \_\_\_\_\_  
\_\_\_\_\_

Sexual/physical/emotional abuse: \_\_\_\_\_  
\_\_\_\_\_

Others living in the home with your child:

Name	Age	Relationship	Grade/Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**MENTAL STATUS**

Please check any of the following that describe how you believe your child has been feeling lately:

sad  anxious  depressed  frightened  guilty  angry  ashamed  aggressive  resentful  
 worthless  tearful  irritable  confused  extreme ups/downs  jealous  hopeless  helpless

Describe any behaviors your child has demonstrated that cause concern: \_\_\_\_\_

\_\_\_\_\_

Has your child had any change in sleeping habits? (Circle One) YES NO Describe: \_\_\_\_\_

\_\_\_\_\_

Has your child had any change in eating habits? (Circle One) YES NO

Describe: \_\_\_\_\_

\_\_\_\_\_

Has your child ever considered suicide in connection with his/her **current** problem? (Circle One) YES NO

If so, please give a brief description with dates: \_\_\_\_\_

Has your child ever **considered suicide** in the **past**? (Circle One) YES NO

Has your child **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: \_\_\_\_\_

\_\_\_\_\_

Has your child tried to hurt others or animals recently or in the past? (Circle One) YES NO

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

**LEVEL OF FUNCTIONING**

Please describe what activities your child participates in: \_\_\_\_\_

\_\_\_\_\_

Who is in your child's support network? \_\_\_\_\_

\_\_\_\_\_

Please describe your child's level of physical activity: \_\_\_\_\_

\_\_\_\_\_

How much time does your child play on the computer, watch TV, or play video games: \_\_\_\_\_

\_\_\_\_\_

Is there any other information regarding your child that you would like to share with your child's Therapist that is not covered on this form? You may also use this space to complete earlier responses.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list your therapy goals for your child:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

THANK YOU!