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Client Information – Child

Child's Information

Child's Name _____Appointment Date:_____

Child's Birthdate: _____ Age:_____

Gender: _____ Pronouns: _____ Ethnicity(ies): _____

Address _____City _____ State ____ Zip code _____

Home Phone: _____Cell Phone: _____Work Phone: _____

Name of School: _____ Grade Level: _____

Parent/Guardian Emergency Contact Information

Parent/Guardian Name #1: _____Birthdate: _____ Age: ____

Address (if different from above) _____

Occupation: _____ Place of Employment: _____

Home phone: _____ Cell Phone: _____ Work Phone: _____
Email address: _____

Parent/Guardian Name #2: _____ Birthdate: _____ Age: ____

Address (if different from above): _____

Occupation: _____ Place of Employment: _____

Home phone: _____ Cell Phone: _____ Work Phone: _____
Email address: _____

Parents are currently: ☐ Married ☐ Divorced ☐ Remarried ☐ Never Married

Child's Siblings and Other People who Live in the Household

Names	Age	Gender	Relationship
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Medical Information

Child's physician: _____ Current medications: _____

Current Health/medical concerns:

_____

What Brings You to This Appointment

Referred by: _____

Child's Presenting Problem/Concerns:

_____

How do the current concerns impact your family?

_____

What are your child's strengths/talents? Family's strengths?

_____

Past counseling? (Please indicate name of therapist, dates, type of treatment, and outcome)

_____

Has there been any abuse of this child? ☐Yes ☐ No If yes, please describe:

_____

Any legal actions pending or history of legal action? ☐Yes ☐ No If yes, please describe:

_____

School concerns/stresses?

_____

Family concerns/stresses?

Developmental History

Pregnancy/Delivery: Any prenatal medical illnesses? _____

Any birth complications or problems? Was the child premature? _____

Milestones

At what age did your child?:

_____ Held head up	_____ Crawled	_____Used sentences
_____ Turned over	_____ Was weaned	_____Was toilet trained
_____ Sat up	_____ Fed self	_____ Slept through night
_____Walked alone	_____ Used single words	_____ Dressed self

Please describe your child's temperament/personality during the first few months of life?:

Medical History List all childhood illnesses, hospitalizations, mediations, allergies, head injuries, important accidents and injuries, surgeries, period of loss of consciousness, convulsions/seizures, and other medical conditions:

Condition	Age	Treated by whom?	Consequences? Consequences?

Family Psychiatric History (Please describe).

Other

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important?

Client/Parent/Guardian Signature Date