Sabine Boots, M.S., LMFT
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Child Information

Child's name: ________________________ Date of Birth: _______ School Grade: ____

Siblings: __________________________ DOB: _________ School Grade: ____

__________________________ DOB: _________ School Grade: ____

Name of Parent: _________________________ DOB: ________

Profession: _____________________________

Spouse/Partner: ___________________________ DOB: ________

Profession: _____________________________

Mailing address:

____

Phone number home: ______________________ Cell: ________________________________

E-mail address: ____

Is it OK to contact you via e-mail? Please initial: Yes ______, No ______ (due to the nature of the Internet safeguarding of information cannot be guaranteed by the therapist)

Referring source (physician/other): ____

Has your child ever seen a psychologist ____, counselor ____, psychiatrist ____, or been admitted to a psychiatric hospital _____? If yes, for what:

____

Is your child currently taking any medications? If yes, which:

____

Did your child develop any health problems that required medical intervention of hospital stay?

Such as: Pneumonia ____ Ear Infection ____ Jaundice ____

Sore throat ____ Scarlet Fever____ Whooping Cough ____

Meningitis____ Rheumatic Fever____ Seizure ____

High Fever____ Surgery ____ Other ____

Did your child stutter or receive speech therapy? _______________________

Did your child ever stop talking once started or lose skills? ________________________________

Has the child ever had an accident, fall or blow to the head/body? ___________________________

If yes to any of the above questions, indicate age and duration ______________________________

What are your child's sleep patterns?

Regular ____ interrupted sleep ____ difficulties going to sleep____

sleep walking ____ Asleep during the day ____ nightmares/terrors ____

difficult to wake up ___ My child sleeps _____ hours a night

Are you worried about your child's eating habits?

If yes, please explain:

____

What are your main concerns about your child at this time?

____

____

____

Please, answer following questions using the numbers 1-5:
1=never, 2=rarely, 3=sometimes, 4=frequently, 5=almost always

1. My child seems to feel stressed at school. _____
2. My child has difficulties making or keeping friends. _____
3. My child lacks concentration. _____
4. My child is easily irritated. _____
5. My child has bowel problems, such as constipation, diarrhea, and/or
   Stomach cramps. ______
6. My child complains of headaches. ______
7. My child does not participate in activities that were previously enjoyable. _____
8. My child seems to lack self-esteem. ______
9. My child has bed-wetting problems. ______
10. My child is "hyper" or "busy" ______

Please have all legal guardians' sign that you are allowing Sabine Boots, LMFT to treat your child In individual psychotherapy and/or family therapy. If I see your child separately, I will update you on his/her progress and advise you in how to integrate the therapeutic gain into your family.

____

Signature guardian 1 Date

____

Signature guardian 2 Date