

REGAIN BALANCE

Counselling, Health & Wellbeing
PO Box 24 Meadows SA 5201
M: 0455 898 325
regain_balance@outlook.com
www.regainbalance.com.au

CONFIDENTIAL CHILD REGISTRATION AND INFORMATION FORM (ONE PER CHILD)

Name of child: _____ Date of Birth: _____ Age: _____

Name of parents/guardians: _____

Address: _____

What is the main concern, reason, or issue for you bringing your child to counselling today?

Please indicate if any of the following are relevant to your child:

- | | | |
|--|--|---|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Difficulty relaxing | <input type="checkbox"/> Self-esteem |
| <input type="checkbox"/> Anxiety/Worry | <input type="checkbox"/> Eating difficulties/disorders | <input type="checkbox"/> Excessive negative talk. |
| <input type="checkbox"/> Bullying | <input type="checkbox"/> Family separation | <input type="checkbox"/> Self-harm |
| <input type="checkbox"/> Birth difficulties | <input type="checkbox"/> Excessive or irrational fears | <input type="checkbox"/> Sleeping difficulties. |
| <input type="checkbox"/> Changes in behaviour | <input type="checkbox"/> Grief/loss | <input type="checkbox"/> Violent behaviour |
| <input type="checkbox"/> Control of emotions | <input type="checkbox"/> Friendships/social interactions | <input type="checkbox"/> Withdrawal |
| <input type="checkbox"/> Cruelty to animals | <input type="checkbox"/> Lack of empathy | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Difficulty self-calming | <input type="checkbox"/> Learning difficulties | <input type="checkbox"/> Obsessive behaviours |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Night terrors | <input type="checkbox"/> Development concerns |

Any other comments you would like to share:

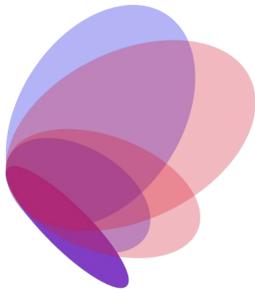
CHILD'S MEDICAL HISTORY

1. Pregnancy

- Full-term
- Premature
- Complications

2. Child's birth

- Natural
- Caesarean
- Complications (including Post-natal depression)



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3. Has your child been diagnosed with?

- Allergies
- Asthma
- Diabetes

Is your child currently taking any regular prescribed medication?

4. Has your child ever been assessed for?

- Autism Spectrum disorders (ASD's)
- Asperger Syndrome
- Attention deficit disorder (ADD) or Attention Hyperactivity Disorder (ADHD)
- Epilepsy
- Headaches
- Mental Illness
- Physical injuries/Illness
- Problems with back, neck, shoulders
- 'Sore tummy' (cramps, ache)
- Other – please specify _____

5. Please indicate if any of the changes listed below have been experienced by child/family in the past two years:

- | | |
|--|--|
| <input type="checkbox"/> Birth of a sibling | <input type="checkbox"/> Changed school or started school |
| <input type="checkbox"/> Child living with other carer's | <input type="checkbox"/> Financial hardship or job loss in family |
| <input type="checkbox"/> Death of close friend or relative | <input type="checkbox"/> Parent remarries or new partner |
| <input type="checkbox"/> Family separation or divorce | <input type="checkbox"/> Serious illness/injury in family |
| <input type="checkbox"/> Moved to a new house | <input type="checkbox"/> Other significant change (please specify) |
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