YOUR LIVING WELL
YOURLIVINGWELL.NET

Child's Full Legal Name:_____Date: _____
Preferred Name:_____ Pronouns:_____ Gender Identity:_____
DOB:_____
Address:_____
Legal status of parents: Married _____ Divorced _____ (*Provide copy of divorce decree*)
The child is adopted Y / N _____ or is in our Foster care Y/N _____
Who lives at the home? (including pets) _____

Were there pregnancy or birth complications? Y/N ____
Born testing positive for any drugs? Y/N_____
Describe Trauma or stress during pregnancy or within the first two years of life? Y/ N_____
Is your child on target developmentally? Physically Y/ N_____; Intellectually Y/ N_____
Has anyone (relatives, early childhood teachers, childcare providers, pediatrician, etc.) ever voiced concern about the child's development? Y/N _____

Symptoms : Check all that your child has experienced as problematic and give brief description. ADD or ADHD behaviors ☐ _____
Anxiety ☐ _____
Fears/Phobias ☐ _____
Won't communicate verbally ☐ _____
Bedwetting ☐ _____
Temper tantrums ☐ _____
Sensitivity to light and noises ☐ _____
Panic Attacks ☐ _____
Obsessive Thoughts ☐ _____
Compulsive Behaviors ☐ _____
Anger/Aggression ☐ _____
Depression ☐ _____
Hypersensitivity to textures and sensations Social Isolation ☐ _____
Issues of Grief/Loss ☐ _____
Verbalized thoughts of dying or wanting to die Cruel to others verbally ☐ _____
Hiding items ☐ _____
School performance issues ☐ _____
Insomnia ☐ _____
Bullies sibling/s ☐ _____
Bullies others ☐ _____
Self-esteem/Identity Issues ☐ _____
Suicide attempt ☐ _____
Homicidal thoughts or threats ☐ _____
Nightmares ☐ _____
Oppositional / Defiant ☐ _____
Cruel to Animals ☐ _____

Other Significant Symptoms:

_____

Do you worry about your child hurting themselves or others?

_____

Describe their appetite and eating habits.

_____

Explain Mental Health Treatment History Previous and current.

_____

Child's Pediatrician – Name and city of clinic:_____ Phone:_____
Child's Psychiatrist- Name and city of clinic:_____ Phone:_____
Please fill out an attached Release of Information Form for your clinician to speak with these doctors.

List All current medications: Mg /Dose Purpose Physician
1.
2.
3.
4.
5.

Has your child been held back or failed a grade Y/N
Describe your child as a student:_____
_____ .
Any CPS case reports or investigations at any time? Yes / No
If yes, Please give case number and dates and details of the findings.
Has your child experienced any of the following events:_____
Major Car Accident:_____
Natural Disaster:_____
Medical Trauma:_____
Domestic Violence:_____
Death of significant person:_____
Multiple moves:_____
Separation from caregiver:_____
High levels of family conflict:_____
Physical abuse or bullying:_____

What are your child's strengths?_____
What are your child's interests?_____
What are your goals for therapy?_____
Does your child want to come to therapy?_____

Signature:_____ Date:_____