Child Client Information Summary

Child's Name:_____________________________Birthdate:______________Age:________________

School:______________________Grade:____Teacher:___________________Counselor:___________

Parent/Guardian:__________________________ Parent/Guardian_____________________________

Address:__________________________________ Address:_____________________________________

City:______________________Zip Code:______ City:________________________ Zip Code:______

Preferred Phone:________________ Msg ok?__ Preferred Phone:__________________ Msg. ok?___

Email address:__________________ Msg ok?__ Email Address:___________________ Msg. ok?___

Does anyone else have access to your e-mail address? ☐ **Yes** ☐ **No**

Marital Status of child's parents/guardians:(Please include the timing of any death/divorce/separation or union)____

____

Living Arrangement

☐ **Parents** ☐ **One Parent** ☐ **Different according to time** ☐ **Guardian**

Pertinent details:____

Please list all family members or other people living in the child's home:

Name Age Gender Relationship to child

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Please list all other family or important people in your child's life:

Name Age Gender Relationship to Child Other Information

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Medical Information:

Current Medical Conditions:____

Medications or Treatments:____

Physician Name:______________________City:________________Phone:__________

EMERGENCY CONTACTS (please list name and phone numbers)

(1) ____

(2) ____

Has your child been in therapy before? No ____ Yes _____

Therapist's Name(s) Dates Reason for Therapy Outcome

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____

Have other family members been in therapy before? No _____ Yes _____

Therapist's Name(s) Dates Reason for Therapy Outcome

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Please describe reason(s) for seeking therapy at this time:

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Please circle any of the following that pertain to your child:

Nervousness	Depression/Sadness	Angry/Aggressive	School Problems	Eating Difficulties
Shyness	Cries Easily	Self-Control	Drug/Alcohol Use	Head/Stomach Aches
Loneliness	Feeling Inferior	Difficult to Discipline	Legal Problems	Sleep Difficulties
Fears	Fatigue	Difficulty with friends	Attention/Memory	Nightmares
Separation	Loss of Interest	Suicidal Thoughts	Difficulty Relaxing	Troubling Thoughts
Anxiety	Day wetting	Day Defecation	Homicidal ideation	Tantrums
Startles Easily	Hypervigilance	Hyperactivity	Lying	Self-Esteem concerns
Stealing	Masturbates excessively	Obsesses	Lack of empathy	Lack of Interest

Dr. Teresa Christensen, NCC, LPC, RPT-S
drchristensen@me.com

Please list major changes your child and/or family have experienced during the past five years:

(e.g. death (people or pets), moves, health changes, family changes, stress, trauma, school or job changes)

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Current Family Substance Use: (Include alcohol, marijuana, nicotine, prescription and non-prescription drugs)

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Other Information:

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__________________________ __________________________

Parent/Guardian Signature Date

__________________________ __________________________

Counselor Signature Date