Family Client Information Summary

Children's Name(s):_____ **Birthdate:**_____ **Age:**_____

Children's Name(s):_____ **Birthdate:**_____ **Age:**_____

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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**

Who has Primary Custody of the child/children? _____

_____

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:_____

Custody/Visitation Arrangements (if applicable): _____

_____

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

Name Age Gender Relationship to child

_____

_____

_____

_____

_____

_____

Please list all other family or important people in child's day to day routine/life:

Name Age Gender Relationship to Child Other Information

_____

_____

_____

_____

_____

Medical Information:

Current Medical Conditions:_____

Medications or Treatments:_____

Physician Name:_____City:_____Phone:_____

EMERGENCY CONTACTS (please list name and phone numbers)

(1) _____

(2) _____

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

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

_____

_____

_____

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

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

_____

_____

_____

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

_____

_____

Please circle any of the following that pertain to your child/children and/or family:

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

Please list major changes experienced by your child/children and/or family during the past few years:

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

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

Other Information:

Parent/Guardian's Signature Date

Counselor's Signature Date