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Client & Family Information

Please fill out this form completely. If there is information that you do not know, or cannot obtain, write in the word “unknown”. This information will be treated in a strictly confidential way. Date:

Name _____Date of Birth _____ Age ____ Sex ___

If MinorParent/Guardian’s Name
_____
_____
_____

Present address
_____
Number street city state zip
Other address?
_____ Home phone _____
Business or cell phone_____
EMAIL _____
Other phone
_____
Religious Preference:_____To what degree do you want to integrate faith with the counseling?_____

Biological or Adopted: _____ If adopted, age of child at adoption:_____
Ethnic Background:_____
Primary Language spoken in the home_____

_____ Single _____ Married _____Divorce

Who referred you to this office? _____

Client Information

Have you had any counseling or are you currently in any type of counseling?
_____

Name, address and phone number of current therapist:
_____
_____

How successful did you find it? Are you currently seeing a psychiatrist?_____

Name, address and phone:
_____
_____

What type of medication(s) do you take?
_____

Why are you taking it?
_____

Does it help?
_____

When was your last physical exam? _____

What were the results?
_____
_____

What is your main concern about you/your child? _____

How long has this existed? _____

In what setting does it occur? Home _____ School _____ Sports? _____
Neighborhood? _____ Public places? _____

For Child:

Do you have any academic concerns?
_____
Was a grade repeated a grade? _____ Which grade? _____
Has there been any abuse? Physical? Neglect? Sexual?
Explain:_____
_____
_____
_____

Would this child say that he/she had many friends? _____ Explain:

Would other adults who observe this child say he/she had many friends? _____
Explain: _____

What are the typical difficulties this child has with brothers and/or sisters?
_____
_____

How does the child express anger?
_____
_____
_____

Was there a time when the child seemed to be doing well in school and/or home?
_____ Describe_____
_____
_____

What does the child do well?
_____
_____
_____

How will you know that things are changing as the process is ongoing?
_____
_____
_____

What do you expect will be different when therapy is completed?

_____
_____
_____

Developmental History Pregnancy and Delivery:

Length of Pregnancy _____
Drugs/Alcohol use during Pregnancy_____
Birth Weight _____
Any pregnancy Complications:_____

Early Childhood:

Check one in each column indicating when child showed development in each area.

CHILD WALKED	CHILD SPOKE WORDS	SPOKE SENTENCES
__ less than 12 months	__less than 12 months	__less than 12 months
__ 12-24 months	__12-24 months	__ 12-24 months
__24-36 months	__24-36 months	__ 24-36 months
__ over 36 months	__ over 36 months	__ over 36 months
__has never walked	__ has never spoken words	__ never spoken sentences

CHILD FIRST TOILET TRAINED:
__less than 12 months
__ 12-24 months
__ 24-36 months
__ 3-5 years
__ over 5 years
__ not yet trained

FOR URINATION FOR BOWELS
__ less than 12 months
__ 12-24 months
__ 24-36 months
__ 3-5 years
__ over 5 years
__ not yet trained

SINCE INITIAL TOILET TRAINING
____ frequent wetting during day
____ frequent wetting during night

SINCE INITIAL TOILET TRAINING
____ frequent soiling during day
____ frequent soiling during night

Explain any of the above:

Puberty

Onset of puberty (breast development, menstruation, pubic hair, facial hair?)
___ under 10 years
___ 10-12 years
___ 12-14 years
___ 14-16 years

___ over 16 years
___ no development

Illnesses and Diseases

Please check any illness or disease which child has had.

__ asthma	__ tuberculosis	__ dizziness
__ eczema	__ heart disease	__ meningitis
__ arthritis	__ influenza	__ broken bone
__ diabetes	__ pneumonia	__ fainting
__ cancer	__ migraine headaches	__ anemia
__ undescended testicles	__ measles	__ high blood pressure
__ mumps	__ low blood pressure	__ chickenpox __ sinusitis
__ diphtheria	__ appendicitis	__ scarlet fever
__ heart surgery	__ polio	__ tonsillectomy
__cerebral palsy	__ convulsions	__ lead poisoning
__ brain injury	__encephalitis	__ other (write in)

List any medications your child is currently taking:

_____
_____
_____
_____
_____

Hospitalizations

List any hospitalizations, age and length of stay.

Condition for which hospitalized	Age	Length of stay
_____	___	_____
_____	___	_____
_____	___	_____
_____	___	_____

Social & Behavioral (circle the items the child has difficulty with.

Use another sheet if needed.)

Auditory	**Focus on objects; not people**	**Phys. aggression**
Bed wetting	**Forgetful**	**Rocking body**
Blanking out	**Giving up**	**Shyness**
Breath holding	**Habits**	**Sibling conflict**
Can't fall asleep	**Head banging**	**Sleep walking**
Clumsiness	**Hyperactivity**	**Social isolation**
Constipation	**Impulsively**	**Slowness to learn**
Coordination	**Interrupted sleep**	**Soiling**
Dangerous behavior	**Mannerisms**	**Speech**
Daredevil behavior	**Nail biting**	**Stubbornness,**
Rigidity	**Diarrhea**	**Night terrors**
Tantrums	**Early waking**	**Nightmares**
Thumb sucking	**Eating**	**Verbal aggression**
Fears	**Vision**	**Other language**
other (describe)		

Family History:

Check all of the following family concerns that apply currently or in the last 6 months:
____Marital difficulties
____Children leaving home
____Aging parents
____Recent death in family
____Alcoholism
____Recent death of friend
____Serious illness of child
____Drug addiction in family
____Serious illness
____Financial problems
____ Birth of a child
____Move to a new house
____Traumatic experience
____ New Job

Has there been anyone in either parent's family who has been treated for mental illness? _____

_____
_____

Or has anyone been on medication for depression, bipolar disorder, or anxiety?

_____
_____
_____

Or has anyone been treated for alcoholism or drugs?

_____
_____
_____

Describe briefly any special interests, hobbies and recreational activities in which family members participate:

Child Mother Father Brothers/Sisters

List All Those Living in Child's Home

Name Relationship Birth date Occupation

List All Other Persons Closely Involved With Child But Not Living in Home

Name Relationship Place of Residence

Describe an important family value

_____
_____
_____

How would you describe the child as a person?

_____
_____
_____

Name of adult completing this form

_____

Relationship to child

_____

Therapist Signature _____ Date_____

IN THE EVENT OF TRANSFERRING, PLEASE FILL OUT:

Transferred to:

_____
_____
_____

Termination date:

_____
_____
_____