Client Information Form CHILD

Today's Date: ***How did you hear about us?***

Personal information

First Name: MI: Last Name:

Birthdate: Age: ☐ Male ☐ Female

Address: City: State: Zip:

To protect your confidentiality, any mail (including billing statements) sent to the above address will arrive in a discrete envelope listing only office's return address.

Contact Information

Home Phone # ☐I give permission to leave a message at this number ☐ I DO NOT give permission to leave a message at this number.

Mobile # ☐ I give permission to leave a message at this number ☐ I DO NOT give permission to leave a message at this number.

Email: ☐ I give permission be contacted by email (email may not be confidential)

What is your preferred method of contact? (mark only one): ☐ Home Phone ☐ Mobile Phone ☐ Email

Parent/Guardian Information

Relationship Status: ☐ single ☐ married ☐ co-habitating ☐ separated ☐ divorced ☐ widowed ☐ engaged

Father: Address: Phone:

Mother Address: Phone:

Step-Father: Involved in counseling? ☐ Yes ☐ No

Step-Mother Involved in counseling? ☐ Yes ☐ No

Emergency Contact Information

Name: Relationship:

Home Phone: Mobile:

Insurance Information

Medicaid: ☐Yes ☐No Medicaid Number: Is Medicaid your ONLY insurance provider? ☐Yes ☐No

Insurance Provider: Employer:

Policy Number/Member ID: Group Number:

Policy Holder's Name: DOB: ☐M ☐F

Policy Holder's Address: Phone Number:

Client's Relationship to Policy Holder: ☐self ☐spouse ☐child ☐other

Employee Assistant Program Provider: Authorization: # of Visits:

Other Payment

☐Out of Pocket/Self-Pay ☐Sliding Scale/Intern Fee:

Child Symptom Screener

	Never	Occasionally	Often	Very Often
Does not pay attention to details or makes careless mistakes with for example, homework?	☐	☐	☐	☐
Has difficulty keeping attention to what needs to be done.	☐	☐	☐	☐
Does not seem to listen when spoken to directly.	☐	☐	☐	☐
Does not follow through when given directions and fails to finish activities.	☐	☐	☐	☐
Avoids, dislikes, or does not want to start tasks that require ongoing mental effort.	☐	☐	☐	☐
Loses things necessary for tasks or activities (toys, assignments, pencils, books).	☐	☐	☐	☐
Is easily distracted by noise or other stimuli	☐	☐	☐	☐
Is forgetful in daily activities.	☐	☐	☐	☐

	Excellent	Above Average	Average	Some Problems	Problematic
Overall school performance.	☐	☐	☐	☐	☐
Reading.	☐	☐	☐	☐	☐
Writing.	☐	☐	☐	☐	☐
Mathematics.	☐	☐	☐	☐	☐
Relationship with parents.	☐	☐	☐	☐	☐
Relationship with siblings.	☐	☐	☐	☐	☐
Relationship with peers.	☐	☐	☐	☐	☐
Participation in organized activities (teams).	☐	☐	☐	☐	☐

	Never	Occasionally	Often	Very Often
Fidgets with hands or feet or squirms in seat.	☐	☐	☐	☐
Leaves seat when remaining seated is expected.	☐	☐	☐	☐
Runs or climbs too much when being seated is expected.	☐	☐	☐	☐
Has difficulty playing, or beginning quiet activities.	☐	☐	☐	☐
Is “on the go” or acts as “driven by a motor.”	☐	☐	☐	☐
Talks too much.	☐	☐	☐	☐
Blurts out answers before questions have been completed.	☐	☐	☐	☐
Has difficulty waiting his or her turn.	☐	☐	☐	☐
Interrupts or intrudes in on conversations or activities.	☐	☐	☐	☐
Is perceived as annoying or irritating.	☐	☐	☐	☐
Engages in negative attention seeking behaviors.	☐	☐	☐	☐

	Never	Occasionally	Often	Very Often
Argues with adults.	☐	☐	☐	☐
Loses temper.	☐	☐	☐	☐
Actively defies or refuses to go along with adults’ requests or rules.	☐	☐	☐	☐
Deliberately annoys people.	☐	☐	☐	☐
Is touchy or easily annoyed by others.	☐	☐	☐	☐
Is angry or resentful.	☐	☐	☐	☐
Is spiteful and wants to get even.	☐	☐	☐	☐

	Never	Occasionally	Often	Very Often
Bullies, threatens or intimidates others.	☐	☐	☐	☐
Starts physical fights.	☐	☐	☐	☐
Lies to get out of trouble or to avoid obligations (i.e., "cons others).	☐	☐	☐	☐
Skips school.	☐	☐	☐	☐
Is physically cruel to people.	☐	☐	☐	☐
Has stolen things that have value.	☐	☐	☐	☐
Deliberately destroys other's property.	☐	☐	☐	☐
Has used a weapon that can cause serious harm (bat, knife, gun).	☐	☐	☐	☐
Is physically cruel to animals.	☐	☐	☐	☐
Has deliberately set fires to cause damage.	☐	☐	☐	☐
Has broken into someone else's home, business, or car.	☐	☐	☐	☐
Has stayed out at night without permission.	☐	☐	☐	☐
Has run away from home overnight.	☐	☐	☐	☐
Has forced someone into sexual activity.	☐	☐	☐	☐

	Not at all	Sometimes	Pretty Much	Very Much	Always
Frequently complains about stomach aches.	☐	☐	☐	☐	☐
Pouts and sulks.	☐	☐	☐	☐	☐
Appears happy.	☐	☐	☐	☐	☐
Unable to make up his/her mind.	☐	☐	☐	☐	☐
Cries often.	☐	☐	☐	☐	☐
Moves slowly.	☐	☐	☐	☐	☐
Complains of headaches.	☐	☐	☐	☐	☐
Demonstrates slow speech.	☐	☐	☐	☐	☐
Spends more time with adults than peers.	☐	☐	☐	☐	☐
Talks a lot.	☐	☐	☐	☐	☐
Spends time alone, isolated in room.	☐	☐	☐	☐	☐
Carefree in spirit.	☐	☐	☐	☐	☐
Self-critical/perfectionistic.	☐	☐	☐	☐	☐
Finds it difficult to leave parents.	☐	☐	☐	☐	☐
Enjoys new situations.	☐	☐	☐	☐	☐
Forgetful.	☐	☐	☐	☐	☐
Easily frustrated.	☐	☐	☐	☐	☐
Tires easily.	☐	☐	☐	☐	☐
Gets angry.	☐	☐	☐	☐	☐
Hostile towards others.	☐	☐	☐	☐	☐
Sullen.	☐	☐	☐	☐	☐
Bowel problems.	☐	☐	☐	☐	☐
Cheerful in nature.	☐	☐	☐	☐	☐
Frequent nausea or vomiting (not from illness).	☐	☐	☐	☐	☐
Temper outbursts.	☐	☐	☐	☐	☐
Neat appearance.	☐	☐	☐	☐	☐
Suicidal thoughts.	☐	☐	☐	☐	☐
Suicide attempts.	☐	☐	☐	☐	☐
Self-harm (cutting, hitting self, hitting self with objects).	☐	☐	☐	☐	☐
Eats poorly.	☐	☐	☐	☐	☐
Falls asleep well.	☐	☐	☐	☐	☐

	Not at all	Sometimes	Pretty Much	Very Much	Always
Refuses to go to school.	☐	☐	☐	☐	☐
Leaves schools during school hours (plays hooky).	☐	☐	☐	☐	☐
Moody or irritable.	☐	☐	☐	☐	☐
Talks about fear of parent/s dying.	☐	☐	☐	☐	☐
Works on tasks enthusiastically.	☐	☐	☐	☐	☐
Sleeps through the night in own bed/room.	☐	☐	☐	☐	☐
Awakens in morning earlier than necessary.	☐	☐	☐	☐	☐
Needs more help from adults than necessary for age.	☐	☐	☐	☐	☐
Generally outgoing.	☐	☐	☐	☐	☐

	Not True/ Hardly Ever True	Somewhat/ Sometimes True	Very True/ Very Often True
When my child feels nervous, it is hard for him/her to breathe.	☐	☐	☐
When my child gets nervous, he/she feels like passing out.	☐	☐	☐
People tell me that my child looks nervous.	☐	☐	☐
When my child gets nervous, she/he feels like they are going crazy.	☐	☐	☐
When my child gets nervous, he/she feels like things are not real.	☐	☐	☐
When my child gets nervous, his/her heart beats fast.	☐	☐	☐
My child gets shaky.	☐	☐	☐
My child gets frightened /nervous for no reason at all.	☐	☐	☐
When my child gets frightened he/she feels like he/she is choking.	☐	☐	☐
My child is afraid of having anxiety (or panic) attacks.	☐	☐	☐
When my child gets nervous, he/she feels like throwing up.	☐	☐	☐
When my child gets nervous/frightened he/she feels dizzy.	☐	☐	☐
My child worries about other people liking him/her.	☐	☐	☐
My child is nervous.	☐	☐	☐
My child worries about things working out for him/her.	☐	☐	☐
My child is a worrier.	☐	☐	☐
People tell me that my child worries too much.	☐	☐	☐
My child worries about what is going to happen in the future.	☐	☐	☐
My child worries about how well she/he does things.	☐	☐	☐
My child worries about things that have already happened.	☐	☐	☐
My child gets scares if she/he sleeps away from home.	☐	☐	☐
My child follows me wherever I go.	☐	☐	☐
My child worries about sleeping alone.	☐	☐	☐
My child has nightmares about something bad happening to him/her.	☐	☐	☐
My child is afraid to be alone in the house.	☐	☐	☐
My child doesn't like to be away from her/his family.	☐	☐	☐
My child worries that something bad might happen to his/her parent/s.	☐	☐	☐
My child doesn't like to be with people he/she doesn't know.	☐	☐	☐
My child feels nervous with people she/he doesn't know well.	☐	☐	☐
It is hard for my child to talk with people he/she doesn't know well.	☐	☐	☐
My child feels shy.	☐	☐	☐
My child feels nervous when she/he has to do something with others.	☐	☐	☐
My child feels nervous going to parties, dances, or new places.	☐	☐	☐
My child gets frequent headaches at school or before going to school.	☐	☐	☐
My child gets frequent stomachaches at school, or before school.	☐	☐	☐
My child worries about going to school.	☐	☐	☐
My child is scared to go to school.	☐	☐	☐

	Yes	No
Does your child have thoughts or obsessions about which they can't stop thinking about? *<u>Obsessions</u> are unwanted or disturbing thoughts/ideas/pictures that keep coming into your child's mind even though he/she does not want them to.*	☐	☐
Does your child engage in compulsions, habits, or rituals which they cannot stop doing? *A <u>compulsion</u> is a behavior that you child feels compelled to do even if they know it doesn't make sense. Examples: excessive hand washing, asking the same question over and over again (even when answered), checking and rechecking.*	☐	☐

Has your child ever experienced/ witnessed any of the following traumatic events?	Yes	No
Natural disaster (flood, hurricane, tornado, earthquake, fire, industrial accident?	☐	☐
Transportation accident (car, boat, train, or plane)?	☐	☐
Physical assault? Describe:	☐	☐
Sexual assault/abuse? Describe:	☐	☐
Combat, exposure to a war-zone, or captivity?	☐	☐
Life threatening illness?	☐	☐
Sudden, unexpected death or injury of someone close to them?	☐	☐
Serious injury, harm, or death to someone else they witnessed?	☐	☐
Does your child experience re-occurring and unwanted flashbacks, nightmares or reminders of the event?	☐	☐
Does your child make efforts to avoid thinking or talking about this event, or doing thing that remind you of it?	☐	☐
Has your child felt less interest in people and things, a feeling of numbness, or trouble experiencing emotions?	☐	☐
Felt nervous, jumpy, or had a sense of heightened alertness?	☐	☐

	Yes	No
Has your child had any unusual experiences such as: hearing voices, seeing visions, having ideas they found out were not true, mind reading, ESP, thoughts of being controlled by others, or seeing thing in TV they think refer to them specifically?	☐	☐
Are you concerned about your child's overall level of development?	☐	☐
Are you concerned about your child's development in areas of speech and language?	☐	☐
Are you concerned about your child's learning development in the areas of mathematics, reading, etc.?	☐	☐
Has your child had problems with social interactions (e.g. eye contact, social reciprocity, making and keeping friends).	☐	☐
Has your child experienced delays in social communication (delay in language, inability to sustain or initiate conversation, "stuttering" like they are having a hard time getting words out?	☐	☐
Has your child displayed restricted, repetitive or stereotyped patterns of behavior, interests, and/or activities?	☐	☐
As your child had any problems with enuresis (wetting the bed, accidents during day)?	☐	☐
As your child had any problems with encopresis (not using toilet, accidents during day)?	☐	☐

Current Concerns

BRIEFLY DESCRIBE THE REASON(S) YOU ARE SEEKING COUNSELING:

About how long have you been concerned about this: ☐ 1 month ☐ 2-3 months ☐ 6 months ☐ 1 year ☐ Other:

DOES IT CAUSE PROBLEMS/STRESS IN ANY OF THE CATEGORIES BELOW?

	None	Mild Stress	Moderate Stress	Severe Stress
Health (include sleep and appetite)	☐	☐	☐	☐
Education/Employment	☐	☐	☐	☐
Housing	☐	☐	☐	☐
Day to day tasks/chores	☐	☐	☐	☐
Finances	☐	☐	☐	☐
Friends	☐	☐	☐	☐
Family/Significant Relationships	☐	☐	☐	☐
Legal System	☐	☐	☐	☐

Describe:

Social Functioning

WHICH BEST DESCRIBES YOUR CHILD'S SOCIAL SITUATION?

☐ Supportive social network/friends ☐Makes friends easily ☐Feels lonely/isolated ☐Few friends

☐ Conflict with peers/classmates ☐Gets bullied ☐Difficult sustaining friendships ☐No friends

☐ Other/Describe:

Family History

Has your child ever experienced parental separation, divorce, or death? ☐ Y ☐N How old was child?

If the parents are separated or divorced, who has custody? ☐ Mother ☐ Father ☐ Joint ☐ Other:

Please describe current custody/legal or foster child arrangements for this child:

Describe child's current family environment: who lives in the home, strengths/stressors, dynamics:

Please list child's siblings (including step-siblings):

Name	Age	M/F	Living in the Home?
			☐ Y ☐N
			☐ Y ☐N
			☐ Y ☐N
			☐ Y ☐N
			☐ Y ☐N

Psychiatric History

IS THERE FAMILY HISTORY OF ANY OF THE FOLLOWING?

MOTHER:
- ☐ ADD/ADHD
- ☐ Alcohol Addiction
- ☐ Substance Abuse
- ☐ Anxiety
- ☐ OCD
- ☐ Depression
- ☐ Bipolar
- ☐ Eating Disorder
- ☐ PTSD
- ☐ Schizophrenia
- ☐ Anger Management
- ☐ Personality Disorder
- ☐ Attempted Suicide
- ☐ Completed Suicide
- ☐ Other:

FATHER:
- ☐ ADD/ADHD
- ☐ Alcohol Addiction
- ☐ Substance Abuse
- ☐ Anxiety
- ☐ OCD
- ☐ Depression
- ☐ Bipolar
- ☐ Eating Disorder
- ☐ PTSD
- ☐ Schizophrenia
- ☐ Anger Management
- ☐ Personality Disorder
- ☐ Attempted Suicide
- ☐ Completed Suicide
- ☐ Other:

SIBLINGS:
- ☐ ADD/ADHD
- ☐ Alcohol Addiction
- ☐ Substance Abuse
- ☐ Anxiety
- ☐ OCD
- ☐ Depression
- ☐ Bipolar
- ☐ Eating Disorder
- ☐ PTSD
- ☐ Schizophrenia
- ☐ Anger Management
- ☐ Personality Disorder
- ☐ Attempted Suicide
- ☐ Completed Suicide
- ☐ Other:

EXTENDED FAMILY/GRANDPARENTS:
- ☐ ADD/ADHD
- ☐ Alcohol Addiction
- ☐ Substance Abuse
- ☐ Anxiety
- ☐ OCD
- ☐ Depression
- ☐ Bipolar
- ☐ Eating Disorder
- ☐ PTSD
- ☐ Schizophrenia
- ☐ Anger Management
- ☐ Personality Disorder
- ☐ Attempted Suicide
- ☐ Completed Suicide
- ☐ Other:

HAS CHILD USED COUNSELING SERVICES IN THE PAST? ☐ **Yes** ☐ **No**

Name of Counselor	Primary Reason	Location	Outcome/Was it helpful?
			☐ Yes ☐ No
			☐ Yes ☐ No

HAS CHILD HAD A PREVIOUS DIAGNOSIS OF

Anxiety ☐ Depression ☐ Panic ☐ ADHD ☐ OCD ☐ Panic ☐ Bipolar ☐ Anorexia ☐ Bulimia ☐PTSD ☐ Substance Abuse ☐ Alcoholism

HAS CHILD EVER BEEN HOSPITALIZED FOR PSYCHIATRIC REASONS? ☐ Yes ☐ No

When/Dates	Location	Purpose	Length of Stay

HAS CHILD EVER ATTEMPTED SUICIDE? ☐ **Yes** ☐ **No** **If Yes, then:**

Dates	Method	**Lethality** (required medical intervention?)

Educational History

Current School	Grade	Teacher
Past Schools	Grades	Teachers

Has your child been diagnosed with any of the following?

☐Cognitive Disorder ☐Autism ☐ Asperger's ☐ Learning Disorder ☐ Severe Head Injury ☐Seizures ☐ Speech/Language Problem

Educational Problems:	☐Math	☐Reading	☐Spelling
☐Dyslexia	☐Hyperlexia	☐Writing	☐Missing Work
☐Behavioral	☐Expressive Language	☐Attention/Focus	☐Frequent Absences
☐Forgets Work	☐Poor Grades	☐Dislikes School	☐Suspensions

Testing or placement for a learning disorder/special education: ☐Y ☐ N

Testing or placement in a gifted and talented program: ☐Y ☐ N

Has child skipped or repeated a grade? ☐Y ☐ N Which grade? _____

Does your child experience behavioral problems at school? Please describe:

Developmental History

PREGNANCY

☐Normal	☐Smoking	☐Severe Morning Sickness	☐Staining or blood loss	☐Threatened Miscarriage
☐Infections	☐Alcohol Use	☐Drug Use	☐Toxemia	☐Other

DELIVERY/POST DELIVERY

☐Full-Term	☐Premature/Wks:	☐Spontaneous/Hrs.	☐Induced/Hrs.
☐Vaginal	☐C-Section:	☐Breech	☐Complications:
☐Jaundice	☐Cyanosis (blue baby)	☐Infection	☐NICU/Days/Wks:

INFANCY (0-6MONTHS)

☐No Issues ☐Separation Anxiety ☐Attachment:
☐Feeding Issues: ☐Excessively Irritable ☐Sleep Problems:
☐Difficult to Comfort: ☐Did not like being held:
☐Head Injuries: ☐Major Illnesses:

DEVELOPMENTAL MILESTONES

	Normal	*Early*	*Late*	*Comments*
Eating Solid Foods	☐	☐	☐	
Sat Without Support	☐	☐	☐	
Crawled	☐	☐	☐	
Walked	☐	☐	☐	
Spoke First Words	☐	☐	☐	
Spoke Sentences	☐	☐	☐	
Fine Motor Skills	☐	☐	☐	
Gross Motor Skills	☐	☐	☐	
Toilet Trained	☐	☐	☐	
Puberty	☐	☐	☐	

Any skills that were gained and then lost? Describe*:*

Sensitivities/low tolerance for: ☐Sounds ☐Lights ☐Foods ☐Textures ☐Other:

Medical Information

Primary Care

Primary Care Physician:

Office Address:

Phone Number: Fax:

Medical History

Current/Past Medical Conditions

☐Heart Disease	☐Anemia	☐Headaches/Migraines	☐Stroke	☐Arthritis	☐Hepatitis
☐Shortness of breath	☐Asthma	☐Diabetes	☐Kidney Problems	☐Cancer	☐Menstrual Problems
☐High Cholesterol	☐Hormone Imbalance	☐Dementia	☐Liver Problems	☐Thyroid	☐Sleep Apnea
☐High Blood Pressure	☐Seizures/Epilepsy	☐Head Trauma	☐Ulcers	☐Fibromyalgia	☐Smoke

Other:

Do you have allergies: ☐ Y ☐ N List:

Are you currently taking medication? : ☐ Y ☐ N

Name of Medication	Dosage	Frequency	Purpose

Family History Of Illness/Disease

☐None ☐ Cancer ☐ Asthma ☐ Heart Disease
☐Diabetes ☐ High Blood Pressure ☐ Thyroid ☐Epilepsy
☐ Dementia/Alzheimer's ☐Hormone Imbalance ☐ Migraines ☐Other:

Current Psychiatric Care

Other Mental Health Providers:

☐ Psychiatrist ☐Developmental Therapy ☐Case Management ☐Service Coordination ☐CBRS ☐Other:

Name of Provider/s	Location	Phone

CURRENT PSYCHIATRIC MEDICATIONS

Name of Medication	Dosage	Frequency	Purpose

Personal Resources

Describe your child's personal strengths and interests:

What you like to see improve as a result of counseling?

Would including spirituality in your child's counseling be beneficial? ☐ Yes ☐ No ☐ Not sure
Describe religious background and/or preference?