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**Child Client Information Form 1**

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**Today's date:** \_\_\_\_\_ **Client #** \_\_\_\_\_

**Note:** If you have been a patient here before, please fill in only the information that has changed.

**A. Identification**

Your child's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Nicknames or aliases: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home street address: \_\_\_\_\_ Apt.: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home/evening phone: \_\_\_\_\_ Calls will be discreet, but please indicate any restrictions: \_\_\_\_\_

**B. Referral:** Who gave you my name to call?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

May I have your permission to thank this person for the referral? • Yes • No

How did this person explain how I might be of help to you? \_\_\_\_\_

**C. Your child's medical care:** From whom or where does your child get his/her medical care?

Clinic/doctor's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

If your child enters treatment with me for psychological problems, may I tell his/her medical doctor so that he or she can be fully informed and we can coordinate your child's treatment? • Yes • No

In the event of an emergency, may I contact your child's medical doctor and disclose necessary information so that he or she can be fully informed and we can coordinate your child's treatment? • Yes • No

**D. Parents Marital Status**

Are the child's parents: Married \_\_\_\_\_ Divorced \_\_\_\_\_ Never Married \_\_\_\_\_

If the parents are divorced, give the month and year the divorce was granted \_\_\_\_\_

Are both parents named as Joint Managing Conservators in the Divorce Decree? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does either parent have primary physical custody of the child? \_\_\_\_\_ Yes \_\_\_\_\_ No

With whom does the child currently live? \_\_\_\_\_

Is either parent remarried? If so, please explain. \_\_\_\_\_

Have either parent's parental rights been terminated by a court? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have either parent's rights to consent to treatment or obtain records of treatment been limited or restricted by a Court Order? \_\_\_\_\_ Yes \_\_\_\_\_ No If the answer is "Yes," please explain: \_\_\_\_\_

**NOTE: IF THE CHILD'S PARENTS WERE DIVORCED PRIOR TO 09/01/1995 OR EITHER PARENT'S RIGHTS HAVE BEEN RESTRICTED BY A COURT, A COPY OF THE PARENTS' DIVORCE DECREE OR APPLICABLE COURT ORDER MUST BE PROVIDED BEFORE ANY SESSIONS WILL BE SCHEDULED.**

**E. Family Members (list those living in home with your child):**

Name	Age	Sex	Grade	Relationship to child
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**F. Medications:**

Name of Medication?	Dosage/Mg?	Frequency?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Client \_\_\_\_\_

**G. Any problems or concerns about your child's medications?** \_\_\_ Yes \_\_\_ No

(If yes have you talked to the prescribing physician? \_\_\_\_\_)

**H. Emergency Contacts:**

List the name(s) of the person(s) who may be contacted by this office in the event of an emergency involving your child. Please be aware that the person(s) listed may receive information in an emergency situation that would otherwise be confidential by law. By listing the name(s) below, you give this office permission to contact the person(s) listed and provide necessary information about your child in the event of an emergency.

\_\_\_\_\_  
\_\_\_\_\_

**I. Chief Concern(s):** Please describe the main difficulty that has brought your child to see me:

\_\_\_\_\_  
\_\_\_\_\_

**J. Has your child ever received counseling services before?** \_\_\_No \_\_\_Yes. If yes,  
When? \_\_\_\_\_ With Whom? \_\_\_\_\_ For What? \_\_\_\_\_ With What results? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**K. Abuse History?** \_\_\_My child was not abused in any way. \_\_\_My child was abused (sexual, physical, emotional, neglect) If your child were abused:

Age of Abuse \_\_\_\_\_ Who did it? \_\_\_\_\_ Whom did you tell? \_\_\_\_\_ Consequences of telling? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**L. Child Developmental History:**

1. Pregnancy and delivery: \_\_\_normal \_\_\_caesarian \_\_\_breach \_\_\_ premature \_\_\_other complications

2. The first few years of life: Breast-fed? \_\_\_\_\_ If so, for how long? \_\_\_\_\_ Any allergies? \_\_\_\_\_  
Sleep patterns or medical problems: \_\_\_\_\_

3. Milestones: At what age did this child do each of these?

Sat without support: \_\_\_\_\_ Crawled: \_\_\_\_\_

Walked without holding on: \_\_\_\_\_ Helped when being dressed: \_\_\_\_\_

Ate with a fork: \_\_\_\_\_ Stayed dry all day: \_\_\_\_\_

Didn't soil his/her pants: \_\_\_\_\_ Stayed dry all night: \_\_\_\_\_

Dressed self completely: \_\_\_\_\_

4. Speech/language development

Age when child said first word understandable to strangers: \_\_\_\_\_

Age when child said first sentence understandable to a stranger: \_\_\_\_\_

Any speech, hearing, or language difficulties? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**M. Health**

List all childhood illnesses, hospitalizations, medications, allergies, head trauma, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition \_\_\_\_\_ Age \_\_\_\_\_ Treated by whom? \_\_\_\_\_ Consequences? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**N. Residences Outside your home?** (Examples would be Foster Care, Residential Placement, etc) \_\_\_ No \_\_\_ Yes (If yes please complete below):

From \_\_\_\_\_ To \_\_\_\_\_ Location \_\_\_\_\_ Reason for moving \_\_\_\_\_ With whom \_\_\_\_\_ Any problems? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**O. Schools**

School (Name, district, address, phone) \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_ Teacher \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Client # \_\_\_\_\_

Any concerns about progress in school? \_\_\_ Yes \_\_\_ No If yes, please list : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Concerns:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(Office Use Only)** Insurance Information:

Name of Insurance Company: \_\_\_\_\_ Effective date of coverage: \_\_\_\_\_

Policy ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ SSN#: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Date of Birth of Policy Holder \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Authorization/Certificate # \_\_\_\_\_ Beg and End Dates: \_\_\_\_\_

# Of Authorized Visits: \_\_\_\_\_ **Benefits:** Deductible: \_\_\_\_\_ Co Pay: \_\_\_\_\_ #Visits per year: \_\_\_\_\_