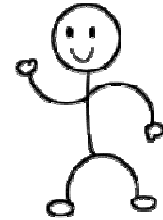


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Child Information Form

Today's Date: _____ Completed by: Mother Father Other
Child's Name: _____ Date of Birth: _____
Address: _____
Home Phone: _____

Mother's Name: _____
Address: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____
Email: _____
Years of Education: _____ Occupation: _____

Father's Name: _____
Address: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____
Years of Education: _____ Occupation: _____

Parents' Marital Status: Never Married Married Divorced/Separated
If divorced, who is legal guardian? _____
Who has physical custody? _____

Siblings (including step-siblings and half-siblings):

<u>Name</u>	<u>Age</u>	<u>Gender</u>
1.		
2.		
3.		
4.		

Others in the home (grandparents, cousins, family friends):

<u>Name</u>	<u>Age</u>	<u>Gender</u>
1.		
2.		
3.		
4.		

Significant Life Events in the Last Two Years

- Death of a loved one
- Move/School change
- Financial problems for the family
- Parental remarriage/ new step-siblings
- Birth of a new sibling
- Trauma (violence, natural disaster, car accident, etc)
- Other _____
- Divorce/Separation
- Medical Problems for any family member
- Legal problems for the family (assault, DUI, etc)

Child's Strengths or Abilities

- Academics/grades Sports Creative (art or music, etc)
- Group involvement (clubs, organizations) Religious involvement
- Sense of humor Care for others

Other: _____

Current Concerns about Your Child

- Behavior at home/school Mood Eating Sleeping
- Suicidal thoughts Academic performance/grades
- Anger/Irritability Difficulty paying attention Peer relationships
- Health Drugs/alcohol Sexual behavior Frequent worries/shyness
- Sensitive to touch, sound, light, motion

Comments: _____

Is there a history of any previous treatment or any evaluations? Yes No

If so, when and by whom?

Educational evaluation: _____

Psychological evaluation: _____

Outpatient therapy: _____

Hospitalization(s): _____

Does your child take medication? Yes No

If so, please list medication(s) and dosage(s): _____

Who is the prescribing physician? _____

Child's Medical History

- Medical problems during pregnancy
- Maternal drug or alcohol use during pregnancy
- Premature birth (if so, weight at birth: _____ gestational age: _____)
- Complications during birth (ex. Emergency C-section, low oxygen, etc)
- Stayed in neonatal intensive care (if so, how long? _____)
- Health problems as a newborn or toddler
- Frequent ear infections
- Asthma or allergies
- Head injuries/concussions/seizures/fevers over 104 degrees
- Serious accidents/hospitalizations
- Surgeries
- Problems with eating or sleeping

Comments: _____

Child's Developmental History

Problems with...?

- Sitting up Walking Talking Toileting Bedwetting
- Writing letters or using scissors Reading or letter identification
- Physical coordination (running, jumping, climbing)
- Responding to discipline or behavior management
- Anger/temper tantrums Fears Sexual play

Other: _____

Child's Academic History

Current School: _____

School location: _____ Grade: _____

Teacher(s): _____

Has your child...?

- Repeated a grade Skipped school Been suspended Been expelled
- Stopped doing homework Been bullied by others Been aggressive at school
- Received an IEP or 504 plan
- Received any special services (OT, PT, Reading, Speech, Self-Contained, etc)

Child's Social Relationships

Does your child have a friend or friends outside the family? Yes No

Do you know them? Yes No

Do his/her friends tend to be: older younger about the same age as your child

How well does your child get along with others?

Family History

Has anyone in your family struggled with (treated or untreated):

- Depression or Bipolar Disorder
- Anxiety
- Learning problems (reading, math, spelling)
- Attention problems
- Excessive alcohol or drug use
- Sexual abuse
- Physical abuse
- Suicide attempts or completed suicide

Do you have any other concerns about your child?
