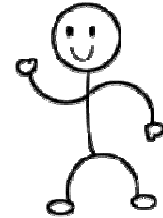


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## Child Information Form

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

Parent's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Years of Education: \_\_\_\_\_ Occupation: \_\_\_\_\_

Parent's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Years of Education: \_\_\_\_\_ Occupation: \_\_\_\_\_

Parents' Relationship Status:  Married  Never Married  Separated  
 Divorced  Partnered  Widowed

If divorced, who is legal guardian? \_\_\_\_\_  
Who has physical custody? \_\_\_\_\_

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

Name	Age	Gender
1.		
2.		
3.		
4.		

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

Name	Age	Gender
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?

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**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?

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