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Child & Family Information

Please fill out this form completely. If there is information you do not know or cannot obtain, write "unknown". If something does not apply, write "N/A." This information will be treated confidentially.

Date _____
Name of adult completing this form _____
Relationship to child _____

Child and Family:

Name _____Date of Birth _____ Age ____ Sex ___
first last

Present address _____
street city state zip

Circle which you are OK with:

Cell phone _____ No messages Voice messages Text
Home phone _____ No messages Voice messages Text
Work phone _____ No messages Voice messages Text
E-mail _____ OK to e-mail Would prefer no e-mails

Parents/Guardians' names: _____
Child biological or adopted: _____
If adopted, age of child at adoption:_____
Child's ethnic background:_____
Primary language spoken in the home_____
Religious preference:_____
Is either biological parent deceased? Yes No
If yes, when and from what cause? _____
Are biological parents married? Yes No
If no, please answer:
Separated? _____ When? _____
Divorced? _____ When? _____
Other marriages? _____

Briefly explain any special living circumstances (foster-care, custody arrangements, visiting rights, etc.):
_____
_____

List all those living in the child's home:

Name Relationship Birth date Occupation

_____

_____

_____

_____

_____

List other persons closely involved with child but not living in the home:

Name Relationship

_____

_____

_____

_____

Current Concerns

What are your main concerns about your child? _____

_____

_____

How long has this existed? _____

In what setting does it occur? Home _____ School _____ Neighborhood ____ Public places_____

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

Please describe:_____

_____

Social & Behavioral Issues **(check the items the child has difficulty with)**

☐ **auditory**	☐ **focus on objects; not people**	☐ **physical aggression**
☐ **bed wetting**	☐ **forgets**	☐ **rocking body**
☐ **spacing out**	☐ **giving up**	☐ **shyness**
☐ **breath holding**	☐ **bad habits**	☐ **sibling conflict**
☐ **frequent crying**	☐ **head banging**	☐ **sleep walking**
☐ **clumsiness**	☐ **hyperactivity**	☐ **social isolation**
☐ **constipation**	☐ **impulsively**	☐ **slowness to learn**
☐ **coordination**	☐ **interrupted sleep**	☐ **trouble focusing**
☐ **dangerous behavior**	☐ **trouble falling asleep**	☐ **speech delays/difficulties**
☐ **anxious feelings/thoughts**	☐ **nail biting**	☐ **stubbornness, rigidity**
☐ **diarrhea**	☐ **night terrors**	☐ **tantrums**
☐ **difficulty making friends**	☐ **nightmares**	☐ **thumb sucking**
☐ **eating**	☐ **verbal aggression**	☐ **fears**
☐ **vision**	☐ **bullying**	☐ **other (describe)**

Past Treatment

Has your child had previous counseling? Yes No

If yes, when, with who, and what were the concerns? _____

_____

_____

How successful did you find it? _____

Is your child currently seeing a psychiatrist?_____

If so, who and for what? _____

Does your child take any psychiatric/psychotropic medication? _____

If so, what medication and for what condition? _____

_____

Trauma History

Has your child been a victim of or a witness to any trauma? _____

__ Physical abuse
__ Sexual abuse
__ Emotional/psychological abuse
__ Neglect
__ Witnessed domestic violence
__ Medical trauma (serious illnesses, injuries, medical procedures, or sicknesses)
__ Serious accident
__ Natural disasters
__ Community violence
__ Other _____

If checked any above, please describe: _____

_____

Family History

Check all of the following family concerns that apply currently or in the last 6 months:

___ Marital difficulties
___ Step-parent home
___ Birth of a sibling
___ Older sibling leaving home
___ Recent death in family
___ Recent death of friend
___ Alcoholism in family
___ Drug addiction in family
___ Serious illness of child
___ Serious illness of another fam. member
___ Financial problems
___ Move to a new house
___ Move to a new school
___ Other (specify) _____

Has anyone in the family been diagnosed or treated for mental illness (including grandparents and aunts/uncles)? ___If yes, please describe: _____

_____

Has anyone in the family been on medication for depression, bipolar disorder, or anxiety?___ If yes, please describe:_____

_____

Has anyone had a problem with alcohol or drugs? If so, please describe:_____

_____

Medical Conditions and History

When was your child's last physical exam? _____

What were the results? _____

Does your child currently take any medication? _____

If so, what and for what purpose? _____

Illnesses and Diseases: Please check any illness or disease which child has had.

__ asthma
__ eczema
__ arthritis
__ polio
__ scarlet fever
__ diabetes
__ diphtheria
__ convulsions
__ mumps
__ cancer
__ anemia
__ measles
__ tuberculosis
__ heart disease
__ influenza
__ cerebral palsy
__ lead poisoning
__ pneumonia
__ appendicitis
__ chickenpox
__ low blood pressure
__ migraine headaches
__ undescended testicles
__ high blood pressure
__ dizziness
__ meningitis
__ broken bone
__ tonsillectomy
__ heart surgery
__ encephalitis
__ sinusitis
__ brain injury
__ fainting
__ frequent ear infections
__ other _____

Hospitalizations: List any hospitalizations, age and length of stay.

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

Developmental History

Pregnancy and Delivery:

Length of pregnancy: _____

Birth weight: _____

Drug/alcohol use during pregnancy: _____

Any pregnancy or delivery complications: _____

Mother and father's acceptance of pregnancy: _____

Family's emotional, social and financial condition at birth: _____

Breastfed or bottlefed and mother's/baby's response to that: _____

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

CHILD WALKED
__ less than 12 months
__ 12-24 months
__ 24-36 months
__ over 36 months
__ has never walked

CHILD SPOKE WORDS
__ less than 12 months
__ 12-24 months
__ 24-36 months
__ over 36 months
__ has never spoken words

SPOKE SENTENCES
__ less than 12 months
__ 12-24 months
__ 24-36 months
__ over 36 months
__ never spoken sentences

CHILD FIRST TRAINED
FOR URINATION
__ 12-24 months
__ 24-36 months
__ 3-5 years
__ over 5 years
__ not yet trained

FOR BOWELS
__ 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

School

Child's school _____# of years attended _____Grade _____
Teacher _____School counselor _____
Does this child have any academic concerns? _____
Has he/she ever repeated a grade? _____ Which grade? _____
Would this child say he/she has many friends? _____
Explain: _____
Would other adults who observe this child say he/she has many friends? _____
Explain: _____

Summing It Up

What is one important family value? _____
_____
How would you describe the child as a person? _____

What are the child's strengths? _____
_____
_____
How will you know that things are changing as counseling progresses? _____
_____
_____
What do you expect will be different when therapy is complete? _____
_____