405 S. Clairborne Ste. 1, Olathe, KS 66062

Child & Family Information

Please fill out this form completely. If there is information that you do not know, or cannot obtain, write in the word "unknown". This information will be treated in a strictly confidential way.

Date completed _____

Child Name _____Date of Birth _____ Age ____ Sex _____
`first last mo., day, yr.

Present address _____
Number street city state zip

Telephone: □ Mobile ( ) _____ □ No messages □ Voice Messages □Text
□ Home ( ) _____ □ No messages □ Voice Messages
□ Work ( ) _____ □ No messages □ Voice Messages □Text

Email Address:_____

Parent/Guardian's Name _____
Date of Birth _____/____/_____ Social Security _____
Employer _____

Employer Address_____
Street City State Zip Phone

Parent/Guardian's Name _____
Date of Birth _____/____/_____ Social Security _____
Employer _____

Employer Address_____
Street City State Zip Phone

Biological or Adopted: _____If adopted, age of child at adoption:_____
Child's Ethnic Background:_____
Primary Language spoken in the home_____ Religious Preference:_____

If child is not currently living with both natural parents
Is either natural parent deceased? ____ If so, when? _____
Were natural parents married? ____ When? _____ Separated? _____
When? ____ Divorced? _____ When? _____ Other marriages? _____
Briefly explain any special living circumstances (foster-care, custody arrangements, visiting rights, etc.)

How long has the child resided at the present address? _____
Does the child share a bedroom with anyone? _____

Who may we contact in the event of an emergency?
Name:_____ Phone number:_____
Relationship?_____

Child's School _____# Years attended _____Grade _____

Teacher _____School Counselor _____

Who referred you to this office? _____

Client Information

Has your child had any counseling or are they currently in any type of counseling? _____
Name, address and phone number of current therapist_____
_____

How successful did you find it?
Are they currently seeing a psychiatrist?_____ Name, address and phone _____
_____
What type of medication does your child take and what is it for?

Medication	**Dose**	**Frequency**	**What for**

When was their last physical exam?(If it has been over a year or presenting symptoms could possibly be the result of a medical issue, suggest that the parents take them in for a check up) _____
What were the results? _____
_____
Physician _____
Name Address Phone #

Does your child regularly have physical wellness check-ups? □ YES □ NO

Please describe briefly the concern or situation, which led you to seek services at this time:
_____
_____

How long has this existed? _____

In what setting does it occur? Home _____ School _____Sports? _____
Neighborhood? _____ Public places? _____

Does this child have any academic concerns? _____
Is your child on an IEP? _____ What for?_____
Has he/she ever repeated a grade? _____ Which grade? _____

Has there been any abuse of the child?
Physical?
Neglect?
Sexual?
Explain:

Would this child say that he/she had many friends? _____

Explain: _____

Would other adults who observe this child say he/she had many friends? _____

Explain: _____

What are the typical difficulties this child has with brothers and/or sisters? _____
_____
How does the child express anger? _____

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

What does the child do well?_____

How will you know that things are changing as the process is ongoing?
_____

What do you expect will be different when therapy is completed?
_____

Developmental History
Pregnancy and Delivery:
Length of Pregnancy _____ Birth Weight _____
Drugs/Alcohol use during Pregnancy_____

Any pregnancy Complications:

Mother and father's acceptance of pregnancy:

Families emotional, social and financial condition at birth:

Breast fed or Bottle fed: Mother's/baby's response to that:

Siblings response to the birth:

Who was baby closest to:

Any moves after child's birth:

Hospitalizations List any hospitalizations, age and length of stay.

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

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
__ less than 12 months
__ 12-24 months
__ 24-36 months
__ 3-5 years
__ over 5 years
__ not yet trained

FOR BOWELS
__ less than 12 months
__ 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

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

__ asthma
__ eczema
__ arthritis
__ diabetes
__ cancer
__ anemia
__ measles
__ mumps
__ chickenpox
__ diphtheria
__ scarlet fever
__ polio
__cerebral palsy
__ lead poisoning
__encephalitis
__ tuberculosis
__ heart disease
__ influenza
__ pneumonia
__ migraine headaches
__ undescended testicles
__ high blood pressure
__ low blood pressure
__ sinusitis
__ appendicitis
__ heart surgery
__ tonsillectomy
__ convulsions
__ brain injury
__ fainting
__ dizziness
__ meningitis
__ broken bone
__ others (write in)
_____
_____
_____
_____
_____

Social & Behavioral (check the items the child has difficulty with. Use another sheet if needed.)

□ Auditory	□ focus on objects; not people	□ physical aggression
□ bed wetting	□ forgets	□ rocking body
□ blanking out	□ giving up	□ shyness
□ breath holding	□ habits	□ sibling conflict
□ can't fall asleep	□ head banging	□ sleep walking
□ clumsiness	□ hyperactivity	□ social isolation
□ constipation	□ impulsively	□ slowness to learn
□ coordination	□ interrupted sleep	□ soiling
□ dangerous behavior	□ mannerisms	□ speech
□ daredevil behavior	□ nail biting	□ stubbornness, rigidity
□ diarrhea	□ night terrors	□ tantrums
□ early waking	□ nightmares	□ thumb sucking
□ eating	□ verbal aggression	□ fears
□ vision	□ other language	□ other (describe)

Family History

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

Marital difficulties _____
Aging grandparents _____
Alcoholism ____
Serious illness of child ____
Serious illness of other family member ____
Birth of a sibling _____
Move to a new house ____
Move to a new school ____
Older sibling leaving home ____
Recent death in family ____
Recent death of friend ____
Drug addiction in family ____
Financial problems ____
Step parent home ____
Traumatic experience ____
Other (specify) _____

Substance Abuse History:

Has your child/adolescent ever attempted suicide? □ YES □ NO
If yes, how and when:_____
_____
Is your child/adolescent suicidal now? □ YES □ NO

Has your child/adolescent to your knowledge ever had alcohol?_____
Has your adolescent ever been arrested for driving under the influence (DUI)? □ YES □ NO

Does your child/adolescent smoke or use tobacco? □ YES □ NO
If yes, how much?_____

Does your child/adolescent use recreational drugs? □ YES □ NO
If yes, what drugs does he/she use and how often?_____

Has there been anyone in either parent's family who has been treated for mental illness?
What Family member **Name of mental illness**
_____
_____

Or has anyone been on medication for depression, bipolar disorder, or anxiety?

What Family member **What Medication** **Name of mental illness**

_____

_____

_____

Or has anyone been treated for alcoholism or drugs? If yes who and what were the results:

_____

_____

Describe briefly any special interests, hobbies and recreational activities in which family members participate:

Child Mother Father Brothers/Sisters

List All Those Living in Child's Home

Name Relationship Birth date Occupation

List All Other Persons Closely Involved With Child But Not Living in Home

Name Relationship Place of Residence

Describe an important family value_____

_____

How would you describe the child as a person? _____

_____

Name of adult completing this form _____

Relationship to child _____

Therapist Signature _____ Date _____