Lifeline COUNSELING CENTER

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? ___________________________________
____

Does it help? ____
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	CHILD SPOKE WORDS	SPOKE SENTENCES
__ less than 12 months	__ less than 12 months	__ less than 12 months
__ 12-24 months	__ 12-24 months	__ 12-24 months
__ 24-36 months	__ 24-36 months	__ 24-36 months
__ over 36 months	__ over 36 months	__ over 36 months
__ has never walked	__ has never spoken words	__ never spoken sentences

CHILD FIRST TRAINED

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

SINCE INITIAL TOILET TRAINING	SINCE INITIAL TOILET TRAINING
____ frequent wetting during day	____ frequent soiling during day
____ frequent wetting during night	____ 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	__ tuberculosis	__ dizziness
__ eczema	__ heart disease	__ meningitis
__ arthritis	__ influenza	__ broken bone
__ diabetes	__ pneumonia	__ others (write in)
__ cancer	__ migraine headaches	________
__ anemia	__ undescended testicles	________
__ measles	__ high blood pressure	________
__ mumps	__ low blood pressure	________
__ chickenpox	__ sinusitis	________
__ diphtheria	__ appendicitis	
__ scarlet fever	__ heart surgery	
__ polio	__ tonsillectomy	
__cerebral palsy	__ convulsions	
__ lead poisoning	__ brain injury	
__encephalitis	__ fainting	

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?
____
____
____
Or has anyone been on medication for depression, bipolar disorder, or anxiety?
____
____
Or has anyone been treated for alcoholism or drugs?
____

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 ____________________