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Child Client Information Form

Today's date: _____ **Client #**_____
Note: If you have been a patient here before, please fill in only the information that has changed.

A. Identification
Your child's name: _____Date of birth: _____ Age: _____ Grade: _____
Nicknames or aliases: _____ Social Security #: _____
Home street address: _____ Apt.:_____
City: _____ State: _____Zip: _____
Home/evening phone: _____ Calls will be discreet, but please indicate any restrictions:_____
_____

B. Referral: Who referred you to my office?
Name: _____ Phone: _____
Address: _____
_____
May I have your permission to thank this person for the referral? Yes No
How did this person explain how I might be of help to you? _____
_____
_____

C. Your child's medical care: From whom or where does your child get his/her medical care?
Clinic/doctor's name: _____ Phone: _____
Address: _____
If your child enters treatment with me for therapy, may I tell his/her medical doctor so that he/she can be fully informed and we can coordinate your child's treatment? Yes No
In the event of an emergency, may I contact your child's medical doctor and disclose necessary information so that he/ she can be fully informed and we can coordinate your child's treatment? Yes No

D. Parents' Marital Status
Are the child's parents: Married _____ Divorced _____ Never Married_____

If the parents are divorced, give the month and year the divorce was granted_____
Are both parents named as Joint Managing Conservators in the Divorce Decree? _____Yes _____No
Does either parent have primary physical custody of the child? _____Yes _____No
With whom does the child currently live?_____
Is either parent remarried? If so, please explain._____
_____
Have either parent's parental rights been terminated by a court? _____Yes _____No
Have either parent's rights to consent to treatment or obtain records of treatment been limited or restricted by a Court Order? _____Yes _____No If the answer is "Yes," please explain:_____
_____
_____

<u>NOTE</u>: A COPY OF THE PARENTS' DIVORCE DECREE OR APPLICABLE COURT ORDER MUST BE PROVIDED BEFORE ANY SESSIONS WITH THE CHILD WILL BE SCHEDULED.

E. Family Members (list those living in home with your child):

Name	Age	Sex	Grade	Relationship to child

F. Medications:

Name of Medication? Dosage/Mg? Frequency?

_____
_____
_____
_____

G. Any problems or concerns about your child's medications?___ Yes _____ No
(If yes have you talked to the prescribing physician? _____

H. Emergency Contacts:
List the name(s) of the person(s) who may be contacted by this office in the event of an emergency involving your child. Please be aware that the person(s) listed may receive information in an emergency situation that would otherwise be confidential by law. By listing the name(s) below, you give this office permission to contact the person(s) listed and provide necessary information about your child in the event of an emergency.

_____
_____
_____

I. Chief Concern(s): Please describe the main difficulty that has brought your child to see me:

_____
_____
_____

J. Has your child ever received counseling services before? __No __Yes. If yes,
When? With Whom? For What? With What results?

_____
_____
_____

K. Abuse History? ___My child was not abused in any way. ___My child was abused (sexual, physical, emotional, neglect) If your child were abused:
Age of Abuse Who did it? Whom did you tell? Consequences of telling?

_____
_____
_____

L. Child Developmental History:

1. Pregnancy and delivery: ____normal ___caesarian ____breech ___ premature ___other complications 2. The first few years of life: Breast-fed?_____ If so, for how long?____ Any allergies? _____
Sleep patterns or medical problems: _____
3. Milestones: At what age did this child do each of these?
Sat without support: _____ Crawled:_____
Walked without holding on: _____ Helped when being dressed: _____
Ate with a fork:_____ Stayed dry all day:_____
Didn't soil his/her pants: _____ Stayed dry all night: _____
Dressed self completely: _____
4. Speech/language development
Age when child said first word understandable to strangers: _____
Age when child said first sentence understandable to a stranger: _____
Any speech, hearing, or language difficulties? _____
_____
_____

M. Health
List all childhood illnesses, hospitalizations, medications, allergies, head trauma, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition Age Treated by whom? Consequences?

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

N. Residences Outside your home**?** (Examples would be Foster Care, Residential Placement, etc) **____ No ___Yes** (If yes please complete below):

From	To	Location	Reason for moving	With whom	Any problems?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

O. Schools

School (Name, district, address, phone)	Grade	Age	Teacher
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any concerns about progress in school? ___ Yes ___ No If yes, please list :_____
_____
_____

_____

(Office Use Only) Insurance Information:
Name of Insurance Company: _____ Effective date of coverage: _____
Policy ID #:_____ Group #:_____ SSN#:_____
Policy Holder Name: _____ Date of Birth of Policy Holder _____
Policy Holder Employer:_____ Phone Number: _____
Authorization/Certificate #_____ Beg and End Dates: _____
Of Authorized Visits: _____ **Benefits**: Deductible: _____ Co Pay: _____ #Visits per year: _____