Child Information Form

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This form is intended to assist your child's therapist in more thoroughly obtaining information which may be helpful and necessary in assessing the needs of your child and the family. Please answer questions as best and thoroughly as possible. I recommend that each parent, if applicable, completes this information in different pen colors so as to provide as much information and perspective as possible. All information will, of course, be kept confidential.

CLIENT DATA

Responsible Party/Parent Name:___________________________ Today's Date:_______________________

Name and phone of person who referred you (if applicable):____

Social Security #: ________________________________

Telephone:
(Home): ___________________________Best time to call:____________May I leave a message?____________

(Work):___________________________ Best time to call:_____________May I leave a message?____________

(Cell):_____________________________ Best time to call:____________May I leave a message?____________

Child's Name:____

Address: ____

____

Age: _______ Birthdate: _______________________Ethnicity: __________________________________

Person To Be Contacted In Case of Emergency:

Name:____Relationship to child _______________________

Address: ____

Telephone: ____

Child's School: _______________________________________Grade:___________________________________

Teacher's Name:_______________________________________

Previous Schools (including nursery or preschool):

___

Is or was the child in day care or an after school program? If so, please give name.

___

What is the main concern that brings your child to therapy?

___

___

Approximately how long has this concern(s) been bothering your child?

___

Describe child's general health: ___

___

MEDICAL INFORMATION

Current Physician: ___ Last Visit: ___

Address: ___ Phone: ___

Other physician(s): ___ Last Visit: ___

Address: ___ Phone: ___

Are there any medical conditions currently being treated? If so please describe and provide treating physicians name:

___

___

Medications Being Taken: ___

___

Child Medical Hospitalizations

Date *Hospital Name* *Reason* *Length of Stay*

____

____

____

History of Child Illnesses

Date *Nature of Condition* *Duration*

____

____

____

Any history of head trauma?____

Please provide any other information you want me to know about your child's health or medical history

____

____

____

Describe the pregnancy and birth with this child (for example: Cesarean birth, stressful pregnancy/delivery, relaxed pregnancy, ill much of the time, any birth trauma, etc.):___________________________________

____

Were alcohol or drugs taken by the child's mother during the pregnancy?____________________________

How would you describe the child as an infant? (for example, colicky, fretful, cuddly, difficulty with nursing or feeding)____

Describe your child's strengths…..your family's strengths______________________________________

____

____

Father's Name (age): ____________________________________Mother's Name (age): ________________

Are both parents living with the child?_______________

Parents: Address and Occupation:

Father: _______________________________________ Mother: _____________________________

If parent (s) do not reside with child, how often do they have contact with child?

____

Brothers and Sisters

Name *Age* *Residence* *Contact how often?*

____

____

____

List below any other people currently living in household:

Name *Relationship* *Age* *Occupation*

____

____

Current Household Income:____

INSURANCE INFORMATION

Primary Insurance company_______________________________ ID #________________________________

Policy number ________________________________Group number _________________________

Subscriber name ____________________ Subscriber SS#_______________ _____________________

Subscriber's relationship to client: Self___ Spouse ___ Parent___ Subscriber birthdate__________

Secondary Insurance company_________________________________ ID #________________________________

Policy number __________________________________Group number __________________________

Subscriber name _____________________ Subscriber SS#________________ _______________________

Subscriber's relationship to client: Self___ Spouse ___ Parent___ Subscriber birthdate__________

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process claims. I also request payment of governmental benefits either to myself or to the party who accepts assignment.

Signature____Date_____/_____/____

I authorize payment of medical benefits to the undersigned physician or supplier for services described on claims.

Signature____Date_____/_____/____

PSYCHIATRIC HISTORY

Have your child ever received psychiatric or psychological treatment of any kind before? Y___ N____

If you checked "Yes" to the above question, please answer the following:

What type of care did your child receive? Inpatient ____ Outpatient _____ Both ____

Did your child's doctor prescribe medication at the time? Y___ N ___ Not Applicable___

If yes, what was prescribed? (include dosages and frequency, if possible):
____
____
____

Circle any of the following that apply to your child:

Headaches (location?)	Stomach Aches	Soiling
Sleepwalking	Difficulties getting to sleep	Fussy Eater
Frequent injuries, cuts, bruises	Nightmares	Frequent Masturbation
Dizzy/fainting spells	Frequent vomiting	Frequently tired
Sleeping too much/too little		Allergies (specify)
Complaints of genital itching/soreness		Bed wetting

Please explain any of the above items you have circled:____

____

____

Please check any of the following which apply to your child:

____Tired, lethargic much of the time
____Difficulty remembering things
____Easily distracted by noises
____Starts many new things without finishing any
____Quick to react on impulse rather than thinking first
____Does things without considering consequences
____Noisy and talkative
____Voice is generally loud
____Does not take no for an answer, pesters and does not give up
____Expects others not to be displeased by own misbehavior
____Attracted to and gets drawn into other's mischief
____Disobeys frequently and needs supervision with constant reminding
____Has difficulty following more than 2 commands or requests (shut off the TV, put your clothes into the hamper, brush your teeth, and take a shower)
____Wants the rules to change and to be the exception
____Regressive behavior (example, acts like a baby)
____Friends are must older or younger than child's age
____Trouble planning and getting organized

____Easily angered, temper tantrums
____Child is mean, harms animals
____Daydreams or seems "spaced out"
____Seems to put self in dangerous situations or does "daredevil" acts.
____Seems to run and move all the time/fidgets
____Rapid and/or extreme changes in mood (happy to angry in a short time span)
____Low self-confidence, does not like self
____Has few friends or difficulties making friends
____Difficulty separating from mother or primary caretaker
____Temper tantrums or rages which are long lasting (up to several hours)
____Seems sad or depressed
____Child talks about death and/or wanting to die or hurt self
____Blames self frequently
____Hoards food
____Sleeps hot
____Has many ideas at once
____Has horrendous nightmares
____Deflects blame onto others
____Interrupts others/intrudes often
____Periods of self-doubt and self-blame

_____Silliness, goofiness….frequently, and difficulty stopping
_____Refusal to eat, unusual food preferences (example: only likes crispy foods, or soup or soft foods)
_____Seems to eat large quantities of food at one time, preoccupation with food
_____Eats mostly/prefers sweets or carbohydrates
_____Talk of not liking body, feeling "fat," and/or dieting
_____Refusal to eat certain types of food
_____Leaving the dinner table immediately after eating and/or going to the bathroom immediately after eating on a regular basis, refusal to eat with others.
_____Frequent and/or explicit "potty talk"
_____Sexual behavior
_____Persistent interest in sex, sexual material
_____Seems to startle easily, jumpy and/or reactive
_____Becomes suddenly fearful or anxious especially with sounds, or when touched
_____Touching self or others in a sexual manner
_____Performs behaviors or rituals over and over in a certain way, play always must be the same
_____Picks at body/self
_____Pulls-out hair, eyelashes, eyebrows, twirls hair constantly, or pulling pet hair
_____Sudden change in school grades
_____Evidence of alcohol/drug use by child (frequent use of eye drops, loss of appetite but craving sweets, room Deodorizer or incense)
_____Sudden change in friends, manner or dress
_____Secretive behavior
_____Frequent missed school days
_____Child is especially sensitive to touch (being touched, particular about clothing or bed clothes being too Scratchy/heavy/rough/or warm/cold?)
_____Fussy about footwear, especially how socks fit and feel and/or tags on clothing
_____Child spins around, likes getting dizzy
_____Child especially does not like movement or spinning
_____Particular sensitivities to noise (puts hands over ears, gets easily frightened by sounds), or smells, or lights (prefers the dark or dim lighting)
_____no particular hand as dominant (right or left hand)
_____Avoidance or difficulty in using small objects like scissors
_____Overreacts or under reacts to painful experiences (rarely seems to notice/get upset, not at all)
_____Avoids or rarely craves messy play or activities
_____Has poor motor coordination (difficulty going up and down stairs)
_____Seems accident prone
_____Often squints, rubs eyes, get headaches after reading
_____Often rocks back and forth
_____Constantly seems to be touching everything(objects, people) or keeps hands in pockets and does not touch Much or like to be touched/hugged, not a cuddler
_____Difficulty getting dressed
_____Current or past difficulty with being moved from one position to another (getting in and out of car for For example
_____Trouble screening out background noise, complains that some certain sounds "hurt," and/or history of ear Infections?____________________
_____Trouble remembering fats/numbers (learning their telephone number or basic Math facts, Or following verbal instructions)
_____ Trouble taking oral tests
_____Avoidance of engaging in conversation especially if there is background noise like TV or radio Or other people talking

____Sensitive to sounds
____Difficulty riding in a car, discomfort with being upside-down or feet leaving the ground
____Twirls/spins self frequently
____Prefers using fingers to silverware
____Trouble learning to ride a bicycle
____Difficulty using scissors (elementary age up)
____Exceptionally verbal
____Difficulty understanding complex, reading material
____Bowel/bathroom problems, frequently constipated or wets bed/pants

Please describe any fears which your child may express or have (example, fear of strangers, the dark, spiders, etc):____

____

In the past, the family has experienced: Please check & put a * if occurred with the past year

____Financial difficulties

____Frequent marital arguments

____Job change(s)

____Moves(s) in residence. When?
____New family member (s)
____Death(s) in the family. Date, who?
____Legal problems
____Death(s) of a pet. Pet name:____
____Change in marital status
____Domestic violence (verbal, emotional, physical, sexual). Police involvement?_______________________
____Physical illness or injury. Who, specify type:____
____Hospitalization. Date, who____
____Changes in school (teacher left, new school, etc.)
____Changes in living arrangements (boyfriend/girlfriend moved-in or out, step-sister or brother moved-in or
____out, grandparent moved-in or out, changes in custody, visitation arrangements, etc.): Please specifiy:___
____
____
____

FAMILY HISTORY: Please indicate if any of the following are or have been present for the child's close biological relatives:

____History of alcohol/drug abuse
____Anxiety problems
____Obsessive Compulsive Disorder (OCD)
____Super sensitivity to sounds, touch, light
____Hospitalization (s) for psychiatric disorder
____Serious changing moods or diagnosed with manic depression or bipolar disorder
____Schizophrenia
____Eating disorder(s)
____Family member(s) with a history of dieting and/or weight fluctuations, and/or preoccupation with food
____Depression/Bipolar Disorder

____Attention Deficit Disorder (ADD/ADHD)
____Teasing in the family about body appearance, weight/contests to lose weight
Other family history of importance:____
____

____
Please describe any other concerns and questions you may have regarding this child and/or your family:
____

____