



## Child Information Form

Today's date: \_\_\_/\_\_\_/\_\_\_

Note: If your child has been a patient here before, please fill in only the information that has changed.

### A. Identification

Child's full name: \_\_\_\_\_ Date of birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_

Nicknames: \_\_\_\_\_

Child's legal guardian: \_\_\_\_\_ Person(s) completing this form: \_\_\_\_\_

Disability status: \_\_\_\_\_  Talk about later

Gender identity: \_\_\_\_\_  Talk about later

Sexual orientation: \_\_\_\_\_  Talk about later

Racial/ethnic identities: \_\_\_\_\_  Talk about later

Religious/spiritual traditions or identity: \_\_\_\_\_  Talk about later

Other ways you identify your child and consider important: \_\_\_\_\_

### B. Family information

Mother/guardian: \_\_\_\_\_ Age: \_\_\_

Best phone number: \_\_\_\_\_ Other phone number: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Location: \_\_\_\_\_

Father/guardian: \_\_\_\_\_ Age: \_\_\_

Best phone number: \_\_\_\_\_ Other phone number: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Location: \_\_\_\_\_

Parents are currently:  Married  Divorced  Separated  Remarried to others  Never married

Other: \_\_\_\_\_

Patient lives with:  Mother  Father  Relative  Guardian  Other: \_\_\_\_\_

Who has legal custody\* of this child?  Mother  Father  Both/either/shared  Relative

Guardian  Other: \_\_\_\_\_

\*Please bring custody or court papers to the first appointment if they exist.



Members of the household and other important persons in the child's life:

Name	Relationship	Age	Sex	Health, behavioral or learning difficulties?	Last grade in school completed, or works as a . . .	How does this person get along with the child?

**C. Emergency information**

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call? Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_ Address: \_\_\_\_\_

**D. Referral**

Who gave you my name to call? Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

How did this person explain how I might be of help to you? \_\_\_\_\_

Is this person's relationship with you  personal or  professional?

If professional, may I have your permission to thank this person for the referral?  Yes  No

Should I consult with this person about the referral?  Yes  No

**E. Current problems or difficulties**

Please describe the main difficulties that led to your bringing this child to see me: \_\_\_\_\_

When did these problems start? \_\_\_\_\_

What makes these problems worse? \_\_\_\_\_

What makes these problems better? \_\_\_\_\_

With therapy, how long do you think it will take for these to get a lot better? \_\_\_\_\_



**F. Development**

*1. Pregnancy and delivery*

Prenatal medical illnesses or problems: \_\_\_\_\_

Maternal substance use:  Alcohol  Tobacco  Medications  Other drugs

Maternal stressors: \_\_\_\_\_

Was the child premature?  No  Yes, by \_\_\_\_\_ weeks. Birth weight: \_\_\_\_\_ Birth length: \_\_\_\_\_

Birth complications or problems? \_\_\_\_\_

*2. The first few months of life*

Breast-fed?  No  If yes, for how long? \_\_\_\_\_ Feeding problems? \_\_\_\_\_

Allergies? \_\_\_\_\_ Sleep patterns or problems: \_\_\_\_\_

Relationship with mother: \_\_\_\_\_

*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 or her pants during day: \_\_\_\_\_ Stayed dry all night: \_\_\_\_\_ Tied shoelaces: \_\_\_\_\_ Buttoned buttons: \_\_\_\_\_ Slept alone: \_\_\_\_\_ Rode bicycle: \_\_\_\_\_

*4. Speech/language development*

Age when child said first word understandable by a stranger: \_\_\_\_\_ Said first sentence understandable to a stranger: \_\_\_\_\_

Any current speech, hearing, or language difficulties? \_\_\_\_\_

*5. Any other current concerns about development?* \_\_\_\_\_

**G. Homes/residences**

If the child was ever placed out of a home, see item 10 under section I, below.

Child's age when moved	Location	Lived with whom?	Reason for moving	Problems there



**H. Education**

How many years of schooling has your child had (including preschool and kindergarten)? \_\_\_\_\_ years.

From (date)	To (date)	School's name and district	Teacher	Special classes or supports?	Did your child graduate?

May I call and discuss your child with the current teacher?  No  Yes If yes, phone number: \_\_\_\_\_

**I. Health and medical care**

1. How is your child's general level of health?  Excellent  Good  Fair  Poor

2. Pediatrician/PCP/Clinic/doctor's name: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

- If your child enters treatment with me for psychological problems, may I tell your child's medical doctor/PCP, so that he or she can be fully informed and we can coordinate your child's treatment?  Yes  No
- If your child sees other doctors or clinics, please check here  and write their names, addresses, and phone numbers on the back of this page.

3. List all childhood illnesses, hospitalizations, medications, allergies, important injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age, or from-and-to ages	Treated by whom? Mark the primary care provider (PCP) with a star.	Effects/outcome



4. List *all* medications, drugs, or other substances your child has taken in the last year—prescribed medications, over-the-counter vitamins, supplements, herbs, and others.

Medication	Dosage? And how often?	For what condition?	When started?	Effects/outcome	Prescribed and supervised by whom?

5. Describe your child's allergies to medications or anything else.

Allergic to	Allergic reaction	Treatment and medications

6. Has your child ever received inpatient or outpatient psychological, psychiatric, drug or alcohol treatment, medications or counseling services before?  No  Yes. If yes, please indicate:

For what (diagnoses)?	From (date)	To (date)	Name of doctor, provider, or agency and location	What kind of treatment?	With what results?



7. Has any other family member been hospitalized for a psychiatric, emotional, or substance use disorder?  
 No  Yes. If yes, please indicate:

Name of family member	For what (diagnoses)?	What kind of treatment?	From (date)	To (date)	With what results?

8. Describe any substance abuse or mental illness in family members (who, relationship, disorder, currently active?): \_\_\_\_\_

9. Has the child had any residential placements, institutional placements, or foster care?  No  Yes. If yes, please indicate:

Age entered	Age left	Program's name	Reason for placement	Problems there

10. Other important family issues (losses, adoption, stepparents, other relatives): \_\_\_\_\_

**J. Abuse history**

Note: If I suspect that there is or has been abuse, I have to report that. Please be aware of this as you answer the questions below, or leave them blank.

This child was not abused in any way.  This child may have been abused.



This child was abused. For the kind of abuse, use these letters: P = Physical, such as beatings; S = Sexual, such as touching/molesting, fondling, or intercourse; N = Neglect, such as failure to feed, shelter, or protect; E = Emotional, such as humiliation, etc.

Child's age	Kind of abuse	By whom? Intimate partner? Relative? Sibling? Other (specify)?	Effects on the child?	Whom did the child tell?	What happened then?

**K. Chemical use by your child**

- 1a. How many caffeine drinks are consumed by your child each day (coffee, tea, colas, energy drinks, etc.)?
- 1b. How often each week are medications (prescription or over the counter) or energy drinks or other chemicals used for alertness? \_\_\_\_\_
2. How much tobacco is smoked or chewed each week? Kind: \_\_\_\_\_ Amount \_\_\_\_\_
3. How many drinks of beer, wine, or liquor are consumed by your child in a typical week? \_\_\_\_\_
4. Did he or she ever drink to unconsciousness, or run out of money because of drinking?  No  Yes
5. Has your child ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner?  No  Yes. If yes, which and when? \_\_\_\_\_
6. Which drugs (not medications prescribed for the child) have been used in the last 5 years? \_\_\_\_\_  
\_\_\_\_\_
7. Do you think that your child has a drug or alcohol problem?  No  Yes. If yes, what kind? \_\_\_\_\_  
\_\_\_\_\_



**L. Legal history**

1. Are you or your child presently being sued, suing anyone, or thinking of suing anyone?  No  Yes. If yes, please explain: \_\_\_\_\_

2. Is your reason for bringing the child to see me related to an accident or injury?  No  Yes. If yes, please explain: \_\_\_\_\_

3. Are you or your child required by a court, the police, or a probation/parole officer to have this appointment?  
 No  Yes. If yes, please explain: \_\_\_\_\_

4. List any contacts with the police, courts, and jails/prisons that  you have had, or  your child has had. Include all open charges and pending ones. Under "Jurisdiction," write in a letter: F = Federal, S = State, CO = County, CI = City. Under "Outcome," write in the *time* and the *type* of sentence you or the child served or must serve: CD = Charges Dropped, AR = Accelerated Release or Alternative Resolution, CS = Community Service, F = Fine, I = Incarceration (jail or prison), PR = PRobation, P = Parole, R = Restitution, O = Other.

Date	Charge/arrest	Jurisdiction	Outcome	Probation/parole officer's name	Attorney's name

5. Your current attorney's name: \_\_\_\_\_ Phone: \_\_\_\_\_

6. Are there any other legal involvements?  No  Yes. If yes, please explain: \_\_\_\_\_

**M. Special skills or talents of the child**

List hobbies, readings, sports, recreational, musical, TV, and toy preferences, etc.: \_\_\_\_\_

**N. Friends of the child**

How many? \_\_\_\_ Their gender:  Only same  Both  Only other





Their ages:  About the same as my child  Mostly older  Mostly younger

Activities with friends: \_\_\_\_\_

Influence of friends on child:  Positive  Negative. Specifics: \_\_\_\_\_

**O. Other**

Is there anything else that is important for me as your child's therapist to know about, and that you have not written about on any of these forms?  Yes, and I have written about it on the back of this page or another sheet of paper.

**Please do not write below this line.**

**P. Follow-up by clinician**

Based on the responses above and on  interview data  records I reviewed  other information: \_\_\_\_\_, I have requested the client's parent/guardian to complete and/or I have completed the following forms:  Chemical use  Risk assessment  MSE  Other: \_\_\_\_\_

Entered child and parent/guardian into phone book  Entered child into birthday book

*This is a strictly confidential patient medical record. Redislosure or transfer is expressly prohibited by law.*

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