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Child Client Information Form

Your cooperation in completing this questionnaire will be helpful in planning services for you. Please answer each item carefully and ask questions if something is not clear. The information provided on this questionnaire is confidential and will not be released without your permission.

Basic Information

Child's Name _____

Parent(s)/Guardian(s) Name(s) _____

Address _____ City/State_____ Zip_____

Parent Primary Phone # _____ OK to leave messages? ☐ Yes ☐ No

Alternate Phone #_____ OK to leave messages? ☐ Yes ☐ No

Parent Email Address: _____

Child's Date of Birth: _____ Age: _____ Ethnicity: _____

Child's Gender: _____ School Grade: _____

Child's School/Daycare: _____

Teacher(s): _____ School Contact Information: _____

Religious/Spiritual Affiliation: _____

Emergency Contact Information

*In case of an emergency, please list the name, address, and phone number of **two** people that are **not** in therapy with you that I would be able to contact in case of emergency with your child.*

Contact #1:

Name: _____ Relationship: _____

Phone Number: _____

Address: _____ City/State: _____

Contact #2:

Name: _____ Relationship: _____

Phone Number: _____

Address: _____ City/State: _____

Please sign below, giving your consent to allow your therapist to contact these individuals in an emergency situation, as deemed so by your therapist.

Signature: _____Date: _____

Child's Family History

Parent's marriages, separations, divorces: _____

_____

Current custody status: _____

Visitation arrangements: _____

_____

What are your main approaches to discipline and which have been most successful? _____

_____

_____

As a parent, what would you most like to work on? _____

_____

_____

As a parent, what are your greatest strengths? _____

_____

_____

Current Household Composition (names, ages and relationship of those living with the child)

Name of Family Members	**Age**	**DOB**	**Relationship to Client**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How many people live in your home, including yourself? _____

Child's History

Please answer the following questions to the best of your knowledge (Circle Yes or No)

Is your child adopted?	YES	NO
Has your child ever been or is he/she currently in Foster Care?	YES	NO
Does your child have any medical problems, injuries, or allergies?	YES	NO
Were there any problems during pregnancy or birth?	YES	NO
Has your child experienced abuse, neglect, significant separations, or other trauma?	YES	NO
Does your child have difficulty at school or daycare?	YES	NO
Does your child get along with peers?	YES	NO
Does your child get along with adults?	YES	NO
Does your child have unusual eating patterns?	YES	NO
Does your child have unusual sleeping patterns?	YES	NO

What are you most concerned about? _____

_____

What changes would you like to see as a result of therapy? _____

_____

What are your child's three greatest strengths? _____

_____

Child's Medical History

Please answer the following questions to the best of your knowledge

Physician _____ Approximate Date of Last Visit _____

Current Medications/Dosages _____

Significant Medical Conditions _____

Has your child previously received any psychiatric, psychological, and/or counseling help? Yes No

If yes, please describe briefly _____

_____

Who suggested you contact me? _____

Please list any other information that you feel may be helpful to me: _____

_____

Thank you for completing this questionnaire!