

CLIENT CONTACT INFORMATION

(*By providing the following, you agree to being contacted by me through all provided forms of communication)

Name of individual completing form: _____

Relationship to child: _____

Occupation: _____

Referred by: _____

Person responsible for bill: _____

Address: _____

City, State, Zip: _____

Parent Information:

Mother: First Name: _____ Middle: _____ Last Name: _____

DOB: ___/___/___ Email Address: _____

Phone: 1) _____ 2) _____ May I leave a message? _____

Address: _____ City, State, Zip: _____

Father: First Name: _____ Middle: _____ Last Name: _____

DOB: ___/___/___ Email Address: _____

Phone: 1) _____ 2) _____ May I leave a message? _____

Address: _____ City, State, Zip: _____

Stepparents :	Name	Address	Phone
_____	_____	_____	_____
_____	_____	_____	_____

How does your child get along with parents/stepparents? _____

Child Information:

First Name: _____ Middle: _____ Last Name: _____

DOB: ___/___/___ Age: _____ Sex: F M (Circle one)

SSN: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ May I leave a message? _____

Siblings:	Full Name _____	Date of Birth _____	Age _____
	Full Name _____	Date of Birth _____	Age _____
	Full Name _____	Date of Birth _____	Age _____
	Full Name _____	Date of Birth _____	Age _____

Who lives in your home with you?

PRIMARY INSURANCE POLICY

Insurance Company: _____

Policy holder: _____

Relationship to Policyholder: _____

ID Number (SSN for Tricare): _____

****Please have your card ready to copy.**

SECONDARY INSURANCE POLICY

Insurance Company: _____

Policy holder: _____

Relationship to Policyholder: _____

ID Number (SSN for Tricare): _____

****Please have your card ready to copy.**

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____ Phone _____

GENERAL BACKGROUND

What school does your child attend? _____ Grade _____ Typical grades received? _____

Extracurricular Activities _____

If your child is employed, please list employer and hours worked _____

Is your child having any problems at school or at work? Yes No (Circle one)

If yes, please describe

What does your child do for fun?

What are your child's strengths and weaknesses?

Strengths= _____

Weaknesses= _____

Family military service? Yes No (Circle one)

If yes, please specify who, when, and where

Family religious preference? _____ Congregation attended? _____

To what ethnic group does your child belong? (Please circle the most applicable group)

African-American Anglo Hispanic Native-American Other (Please provide)

PHYSICAL HEALTH

List current and past health problems, including operations, hospitalizations, and serious accidents or injuries for your child. Please include approximate dates.

Who is your child's Primary Care Provider (family doctor)? _____ Phone: _____
Address? _____

List any other doctors your child is seeing currently and describe what they are treating.

List ALL medications, vitamins, and supplements (including homeopathic) your child is taking. Please include dosages.

Does your child ever take medication **NOT** as prescribed? _____ If yes, please describe _____

How much does your child weigh? _____ pounds How tall is your child? _____ feet _____ inches

Does your child have any allergies? _____ If yes, specify _____

DAILY HABITS

How many meals does your child eat on a typical *weekday*? _____ How many meals does your child eat on a typical *weekend* day? _____

Does your child participate in a regular exercise routine? Yes No (Circle one)

If yes, please describe

Does your child currently use?				Has your child used in the past?			
Tobacco	Yes	No	DK	Tobacco	Yes	No	DK
Caffeine	Yes	No	DK	Caffeine	Yes	No	DK
Alcohol	Yes	No	DK	Alcohol	Yes	No	DK
Recreational drugs	Yes	No	DK	Recreational drugs	Yes	No	DK

How does your child manage stress?

Does your child have any problems sleeping? _____ If yes, please describe _____

EMOTIONAL PROBLEMS

Briefly describe the problem or concern that brings you here today and when it began.

Describe any significant changes or stressors in your child's life in the last year.

If your child has seen a counselor, psychologist, or psychiatrist in the past, please give their names, approximate dates seen, and what they treated.

Name	Approximate Dates Seen	Treated

Is your child currently seeing another therapist? Yes No (Circle one)

If yes, please provide their name and contact info

Has your child ever been in treatment for substance abuse? Yes No (Circle one)

If yes, please provide details (e.g., substance, dates, time sober, etc)

Has your child ever experienced any of the following? (Circle Yes or No for each item below)

Sexual Abuse	Yes	No	Physical Abuse	Yes	No
Emotional Abuse	Yes	No	Victim of Crime	Yes	No
Eating Disorder	Yes	No	Suicide Attempt	Yes	No

If yes to any item above, please describe and include ages

If anyone in your child's family (e.g., mother, father, siblings, grandparents, uncles, aunts, cousins) has experienced substance abuse, schizophrenia, bipolar disorder (i.e., manic-depression), depression, eating disorders, or other major emotional problems, please list the emotional problem and your child's relationship to them.
