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Personal Information (Child) – Psychotherapy

Child's Name:_____ Today's Date: _____
Person completing form: _____ Role: _____ (i.e. mother, father)

Child Date of Birth: _____ Age: _____ SS#: _____
School: _____ Grade Placement: _____
Name of Teacher(s):_____

Child's Home Address: _____(city)_____ (state) _____ (zip) _____
Mother's Name: _____ Date of Birth: _____ Phone: _____
Mother's Address: _____(city)_____ (state) _____ (zip) _____
Mother's Employer: _____ Occupation: _____
Employer Address: _____ Work Phone: _____
Father's Name: _____ Date of Birth: _____ Phone: _____
Father's Address: _____ (city)_____ (state) _____ (zip) _____
Father's Employer: _____ Occupation: _____
Employer Address: _____ Work Phone: _____
Stepmother's Name: _____ Date of Birth: _____ Phone: _____
Stepmother's Address: _____(city)_____ (state) _____ (zip) _____
Stepmother's Employer: _____ Occupation: _____
Employer Address: _____ Work Phone: _____
Stepfather's Name: _____ Date of Birth: _____ Phone: _____
Stepfather's Address: _____ (city)_____ (state) _____ (zip) _____
Stepfather's Employer: _____ Occupation: _____
Employer Address: _____ Work Phone: _____

Other Family Members
Name: _____ M/F Date of Birth: _____ Where Living: _____
Name: _____ M/F Date of Birth: _____ Where Living: _____
Name: _____ M/F Date of Birth: _____ Where Living: _____
Name: _____M/F Date of Birth: _____ Where Living: _____

Primary Physician: _____ Phone: _____
Address: _____ Fax: _____
Date of last physical exam: _____ Email: _____
Type and Dosage of Child's Medications: _____

Referred by: _____ Relationship: _____
Address: _____ Phone: _____
Email: _____

Why is your child coming in for treatment at this time? _____
_____
_____
_____
_____

At what age was this problem(s) first noted: _____

In what areas does the problem(s) interfere with your child's current functioning (i.e. family, school/academic, peer relationships, etc.): _____
_____
_____
_____

What do you identify as your child's greatest strengths: _____
_____
_____

What is the most important goal(s) you want to achieve during these sessions? _____
_____
_____
_____

Has your child been evaluated or tested before: If so, please list dates and name of evaluator. Please sign release of information for each evaluator and provide me with copies of any evaluations.

Evaluator	Dates	Reason for Evaluation
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any major stresses you have experienced in the past five years: _____
_____
_____
_____

Please list any history of serious physical or mental illness of any family member: _____
_____
_____
_____

Has your child seen a therapist or psychiatrist before? _____ If yes, please provide the following:

When/where in treatment:	Type/Length of Treatment:	Outcome (i.e. was it helpful?):
_____	_____	_____

Birth History

Is your child adopted? _____ If yes, please give age when adopted: _____

Was this a planned pregnancy? _____ Length of this pregnancy: _____
Were any miscarriages suffered? _____ Number of miscarriages: _____

Any difficulties suffered during this pregnancy? _____ If yes, please describe in detail: _____
_____
_____
Were any medications given during pregnancy? _____ If yes, please describe in detail: _____
_____

Length of Labor: _____ Type of delivery: _____ (i.e. vaginal, cesarean, breech)

Any difficulties during delivery? _____ If yes, please describe in detail: _____
_____
_____

Baby's Condition at Birth

Cord around neck:	No	Yes	Injured during birth:	No	Yes	Breathing difficulty:	No	Yes
Required oxygen:	No	Yes	Turned blue:	No	Yes	Had an infection:	No	Yes
Placed in incubator:	No	Yes	Difficulty sucking:	No	Yes	Jaundiced:	No	Yes

Please list any other problems at birth: _____
_____
_____

Genetic or congenital conditions? Please specify: _____
_____
_____

Early Life Difficulties

Feeding difficulties:	No	Yes	Age: _____	Poor Appetite:	No	Yes	Age: _____
Unwillingness to try new foods:	No	Yes	Age: _____	Very unpredictable appetite:	No	Yes	Age: _____
Extreme hunger:	No	Yes	Age: _____	Colic:	No	Yes	Age: _____
Constipation:	No	Yes	Age: _____	Headaches:	No	Yes	Age: _____
Stomach aches:	No	Yes	Age: _____	Trouble falling asleep:	No	Yes	Age: _____
Very unpredictable length of sleep:	No	Yes	Age: _____	Very heavy sleeping:	No	Yes	Age: _____
Overactivity:	No	Yes	Age: _____	Head banging:	No	Yes	Age: _____
Rocking in bed:	No	Yes	Age: _____	Temper tantrums:	No	Yes	Age: _____
Self-destructive behavior:	No	Yes	Age: _____	Difficulty being comforted/consoled:	No	Yes	Age: _____
Stiffness or rigidity:	No	Yes	Age: _____	Looseness or floppiness:	No	Yes	Age: _____
Crying often/easily:	No	Yes	Age: _____	Shyness with strangers:	No	Yes	Age: _____
Bashful with new children:	No	Yes	Age: _____	Irritability:	No	Yes	Age: _____
Extreme reaction to noise/sudden movement:	No	Yes	Age: ____	Difficulty keeping to a schedule:	No	Yes	Age: _____
Failure to be affectionate toward parents:	No	Yes	Age: ____	Unwillingness to go along w/change in daily routine	No	Yes	Age: _____
Tendency to make odd sounds, grunts, snorts:	No	Yes	Age: _____	Tendency to twitch or jerk arm(s) or head often:	No	Yes	Age: _____

Early Development

Sat up without help:	____ Months	____Years	Crawled:	_____ Months	_____Years
Walked alone (10-15 steps):	____ Months	____Years	Walked up stairs:	_____ Months	_____Years

Rode a tricycle: ____ Months _____Years
Spoke first words: ____ Months _____Years
Spoke clearly so strangers understood: __ Months __Years
Used a spoon: ____ Months _____Years
Fully bladder trained: ____ Months _____Years
Able to tie shoelaces: ____ Months _____Years
Caught a ball: _____ Months _____ Years
Put words together: _____ Months _____Years
Used fingers to feed self: _____ Months _____Years
Fully bowel trained: _____ Months _____Years
Able to dress self: _____ Months _____Years
Able to separate easily from mom (school/play): _____ Months _____Years

Learning History

Did child attend preschool? _____
Were any problems noted with behavior? _____
Were any problems noted with learning? _____ At what age? ____ Please specify learning problems:
_____
_____
Is child receiving any special education services? _____ If so, please identify services: _____
_____
Was child ever retained or recommended to be retained? _____ If so, at what age/grade? _____
Does child have difficulty making friends? _____
Does child have difficulty keeping friends? _____
Does child prefer having younger friends? _____
Does child prefer having older friends? _____

Family Medical History

Family medical history (i.e. diabetes, seizures, neurological problems, cardiac problems, metabolic problems, attention deficit disorder, learning disorders, depression, anxiety, manic-depression, schizophrenia, motor ties, obsessive-compulsive disorder, suicide, alcoholism, substance abuse, etc.): _____
_____
_____
_____
_____

Child's Medical History

Head injury:	No	Yes	Age: _____
Loss of consciousness:	No	Yes	Age: _____
Motor tics or vocalizations:	No	Yes	Age: _____
Ear infections:	No	Yes	Age: _____
P.E. tubes:	No	Yes	Age: _____
Meningitis:	No	Yes	Age: _____
Seizures:	No	Yes	Age: _____
Injuries:	No	Yes	Age: _____
Bowel problems:	No	Yes	Age: _____
Chicken Pox:	No	Yes	Age: _____
Measles:	No	Yes	Age: _____
Asthma or allergies:	No	Yes	Age: _____
Food allergies:	No	Yes	Age: _____
Other allergies:	No	Yes	Age: _____
Hospitalizations:	No	Yes	Age: _____
Slow weight gain:	No	Yes	Age: _____

Heart problems: No Yes Age: _____
Others: No Yes Age: _____

Any serious or chronic illnesses: _____ If yes, please specify: _____
_____
_____

Any surgeries? _____ If yes, please specify: _____
_____
_____

Any hearing or vision problems? _____ If yes, please specify: _____
_____
_____

Date of last vision exam: _____
Date of last hearing exam: _____

Please note any other concerns/issues you would want me to be aware of as we start working together: _____
_____
_____
_____
_____
_____
_____
_____
_____