Children's Therapy
CLIENT INFORMATION

Date _____

Child's Name First _____ MI _____ Last _____

Parent/Guardian Name #1 First _____ MI _____ Last _____

Parent/Guardian Name #2 First _____ MI _____ Last _____

Address (including zip code) _____

Phone (_____) _____ - _____ Cell (_____) _____ - _____

Email Address _____

May we leave a message on home phone? ❑ Yes ❑ No Cell phone? ❑ Yes ❑ No Email? ❑ Yes ❑ No

Would you like to receive our monthly eNewsletter*? ❑ Yes ❑ No

What is your preferred method for receiving correspondence? This includes weekly appointment reminders and other useful information. ❑ Phone ❑ Text ❑ Email only* ❑ Facebook/Social Media*

Date of Birth _____ / _____ / _____ Age _____ Gender ❑ Male ❑ Female ❑ _____

Emergency Contact _____ Phone of contact person _____

Referral Source ❑ Self ❑ Friend ❑ Internet ❑ Psychology Today ❑ Other _____

List Any Medication Allergies _____

Please list all medications your child is currently taking and dosage if known

Medication #1 _____ Dosage _____

Medication #2 _____ Dosage _____

Name current/previous psychiatrist _____ Phone (_____) _____ - _____

Mark areas of your concern with scale of severity, circle one

Depression	(low)	1	2	3	4	5	6	7	8	9	10	(high)
Anxiety/Panic Attacks	(low)	1	2	3	4	5	6	7	8	9	10	(high)
Mood Swings	(low)	1	2	3	4	5	6	7	8	9	10	(high)
Anger Outbursts	(low)	1	2	3	4	5	6	7	8	9	10	(high)
Difficulty with Attention/Focus	(low)	1	2	3	4	5	6	7	8	9	10	(high)
Difficulty with Peer Relationships	(low)	1	2	3	4	5	6	7	8	9	10	(high)
Difficulty in School	(low)	1	2	3	4	5	6	7	8	9	10	(high)
Strained relationship with parent	(low)	1	2	3	4	5	6	7	8	9	10	(high)
Behavioral Issues Home/School	(low)	1	2	3	4	5	6	7	8	9	10	(high)

** PLEASE NOTE — Email and Social Media correspondence is not considered to be a confidential medium of communication.*

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LIST ANY MENTAL HEALTH DIAGNOSIS, IF KNOWN

Diagnosis #1 _____ Diagnosis #2 _____

Diagnosis #3 _____ Diagnosis #4 _____

Main purpose of joining the group _____

Has your child received therapy services in the past? ❑ Yes ❑ No Was therapy helpful? ❑ Yes ❑ No

Why? _____

Does your child have a history of Suicide Attempts? ❑ Yes ❑ No

Dates, how many times, method _____

Does your child have a history of Self Injurious Behaviors? ❑ Yes ❑ No

If yes, please describe _____

Have there been any serious losses or deaths in your child's life? ❑ Yes ❑ No

If yes, please describe _____

Does your child have a history of Substance Abuse? Yes No

If yes, please describe _____

LEGAL HISTORY

Does your child have a legal history of misdemeanor or felony law violations? ❑ Yes ❑ No

If yes, please describe _____

Is your child currently on probation? ❑ Yes ❑ No

If yes, please describe _____

Does your child have a history of physical abuse? ❑ Yes ❑ No

If yes, please describe _____

Does your child have a history of sexual abuse? ❑ Yes ❑ No

If yes, please describe _____

Does your child have a history of neglect? ❑ Yes ❑ No

If yes, please describe _____

Does your child have a history of Foster Care or placements outside the home? ❑ Yes ❑ No

If yes, please describe _____

Does your child have a history of witnessing Domestic Violence? ❑ Yes ❑ No

If yes, please describe _____

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Does your child have close friends? ❑ Yes ❑ No Does your child engage in social activities? ❑ Yes ❑ No

If yes, please describe _____

Does your child play sports? ❑ Yes ❑ No

If yes, please describe _____

Does your child do well in school? ❑ Yes ❑ No Does your child like school? ❑ Yes ❑ No

If no, please describe _____

What activities/hobbies does your child enjoy? _____

_____

PERSONAL HABITS

How many hours per night does your child sleep on average? _____

Does your child have any medical conditions affecting their sleep? ❑ Yes ❑ No _____

Does your child wake feeling rested? ❑ Yes ❑ No

Does your child experience difficulty falling asleep? ❑ Yes ❑ No Staying asleep? ❑ Yes ❑ No

Does your child have a history of Head Trauma? ❑ Yes ❑ No

Is your child experiencing Chronic Pain? ❑ Yes ❑ No

If yes how long? _____

Is your child taking pain medication? ❑ Yes ❑ No

If yes, please describe _____

What are your expectations/goals for treatment?

Goal #1 _____

Goal #2 _____

Goal #3 _____

Any additional questions or comments?

_____

_____

_____

_____

_____

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