Associates in Family Psychology
Child Client Information Form

Today's Date: ______________

Client Name: ______________ ______________ ______________
First Middle Last

Parent's Name: ______________

Client's Birth Date: ______________

Home Address: *(no po boxes please)*

____

______________ ______________ ______________
City State Zip Code

Other Parent's Name: ______________

Parents' Marital Status (Check One):
Single Married Divorced Separated Widowed

Number to Call For Appointment Reminders:

____

Parent's Date of Birth:
Mother ______________ Age ______
Father ______________ Age ______

Alternate Number: ______________

Mailing Address if Different From Above:

____

____

Phone Number of Noncustodial Parent:
(if applicable) ______________

Child's School: ______________

Grade: ______________

Emergency Contact:

____

Emergency Contact Phone Number:

____

Mother's Business Name/Occupation:

____

Business Address: ______________
City/State/Zip: ______________
Business Phone: ______________

Father's Business Name/Occupation:

____

Business Address: ______________
City/State/Zip: ______________
Business Phone: ______________

Please let us know how you found out about
Associates In Family Psychology (Specify):

Doctor ______________
Attorney ______________
Friend ______________
Yellow Pages
Public/Private Agency ______________
Insurance ______________
Other ______________

FAMILY INFORMATION: Please list all family members (including child being seen, siblings, half, step, adult, and adopted children)

Name	Gender	Age	Birth Date	School	Grade	Live at Home?
	M F					Y N
	M F					Y N
	M F					Y N
	M F					Y N
	M F					Y N
	M F					Y N
	M F					Y N

Your assistance by providing the following background information about your child/family in advance is greatly appreciated. This will help your psychologist most efficiently address your concerns. This portion of the form will be part of your confidential clinical file. Your psychologist will review this information with you during the intake; however, if you have specific questions about completing this form, please ask a member of our office staff.

Please briefly describe what brings you here today:

____

____

____

____

____

Your Child's Developmental History:

Pregnancy/Delivery:

- Healthy Pregnancy? Yes No
- Full Term Delivery? Yes No
- Healthy at Birth? Yes No
- Extended hospital stay necessary? Yes No

Birth weight: ________ lbs. ________ oz.

Briefly describe any concerns/difficulties regarding the conception, pregnancy, labor, or delivery of your child:

____

____

How would you describe your child as an infant/toddler?

Healthy – happy baby? Yes No

Easy to soothe? Yes No

Colicky? Yes No

Excessive tantrums? Yes No

Were developmental milestones met "on time"? Yes No

When did your child begin walking? _____________ When did your child begin talking? ______________

Did you have toilet training concerns? Yes No Age completed? __________________________

Additional Information (as needed):

____

____

Additional developmental information:

History of ear infections?	Yes	No	Problems with self-regulation/self-control	Yes	No
History of seizures/convulsions?	Yes	No	Problems with authority?	Yes	No
History of brain injury?	Yes	No	Problems with behavioral compliance?	Yes	No

Please provide your psychologist with information regarding your **family** health and emotional history by marking the appropriate column where those problems were present for a particular family member.

Problem Area	Child/ Teen	Mom	Dad	Sibling	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative Specify:
Depression									
Anxiety									
Panic Attacks									
Obsessions/ Compulsions									
Manic depression/ Bipolar disorder									
Psychotic disorder; Hallucinations/delusions									
Alcoholism									
Drug Abuse									
Suicide Attempt									
Learning Problems: Reading, Math, Writing									
AD/HD (Attention Deficit/Hyperactivity Disorder)									
Autism/ Aspergers Syndrome									
Physical, Emotional, or Sexual Abuse									
Eating Disorder									
Thyroid Disorder									
Migraine Headaches									
Serious/chronic health concerns or illness Specify:									
Other:									

Any additional information as needed:

____

____

____

Family History:

City/State where child was born:

Child's relationship with family/siblings: Good Distant Poor Excessive arguing/fighting

Briefly describe as needed:

____

____

Parental Relationship:

Parents' Current Status: Single Married Widowed Separated Divorced Remarried Other

____

Divorce/Custody/Visitation Concerns:

____

Is there parental/marital conflict? Yes No

Does the child directly witness arguing/fighting? Yes No

Is the child indirectly aware of arguing/fighting? Yes No

(If yes, specify):

____

____

Is there domestic violence in the home? Yes No

(If Yes): For how long? ______________ How recently? ______________

Child's Mental Health Treatment History (include inpatient and outpatient): No Prior Treatment

Provider	Dates of Treatment	Reason for Treatment	Problem/Concern Resolved?
			Yes No
			Yes No
			Yes No
			Yes No

Has your child ever attempted suicide or talked of wanting to harm him/herself? Yes No

If yes, please specify and describe current status:

____

____

____

Child's Medical History:

Current Physician(s): ______________________________

Current or prior health problems:

____

____

Hospitalizations? Yes No N/A (If Yes, relevant history):

____

____

Currently Taking Medication? Yes No If Yes, please complete below.

Medication Name	Dosage	Reason Taken	Taken for how long?

Sleep: No concerns Concerns (check all that apply):

Trouble falling asleep

Trouble staying asleep

Early waking

Nightmares

Unusual sleep behavior – Describe: ____________________

Weight/Eating/Appetite Concerns: No concerns Concerns (check all that apply):

Eating too much/weight gain

Not eating enough/weight loss

Concerned about a possible eating disorder

Academic History:

Current School: ____________________ Grade Level: ____________

Most recent academic grades: ____________ Are these grades typical for your child? Yes No

Has your child ever repeated a grade? Yes No If yes, which grade(s)? ____________

Are you concerned about your child's academics? Yes No

Are you concerned about your child's behavior at school? Yes No

Does your child have an Individual Education Plan (IEP) or any accommodations at school? Yes No

Social History/Peer Relationships:

How do you best describe your child's current friendship network?

Many good friends A few close friends Almost no friends Several friends, but poor quality

Makes friends, but has difficulty keeping them

Briefly describe concerns as needed:

____

____

Traumatic Experiences: Yes No (If Yes, specify below):

Physical Abuse Verbal/Emotional Abuse Sexual Abuse Neglect A death/other significant loss

At what age? ____________ Lasting for how long? ____________________

Moves/Relocation (Please note place and dates of relocation):

____

____

Occupational/Educational Background:

Has your child ever held a job? Yes No Too young

Job/Occupational History:

____

____

Legal History:

Has your child ever been in trouble with the law? Yes No

If Yes, relevant history:

____

____

Child's Substance Use History:

No substance abuse
Social drinking
Current alcohol/drug abuse
Prior substance use, but discontinued
Current/Prior substance treatment

Tobacco use
Caffeine
Steroids
Marijuana
Specify: ______________________________

Cocaine
Other

Concerns about parent's/family member's substance use? Yes No

If Yes, please explain:

____

____

Other Concerns: None

Running away Promiscuous/Unprotected sex Unplanned Pregnancy Abortion Gambling
Victim of unusually harsh discipline Self-harm/cutting Abusive/controlling relationship

Explain as needed:

____

____

____

Please describe what you would like to accomplish in treatment with your psychologist:

1. ______________________________

____

2. ______________________________

____

3. ______________________________

____

4. ______________________________

____