


Child Information Sheet

Child's Name: _____ **Age:** _____ **Date of Birth:** _____

Address: _____ **City/State/ZIP:** _____

Primary Phone: H C W _____ **Email:** _____

Mother's Name: _____ **Occupation:** _____

Father's Name: _____ **Occupation:** _____

Parent Relationship Status:

Never Married Married Partnered Divorced Separated Widow/ Widower

Court Ordered Custody Status: None Sole Legal Joint/Share Legal

(Please note that if there is a custody agreement, you must bring a copy of this. If there is joint/shared custody, both parents need to sign all of the forms prior to the appointment before your child can be seen).

How did you hear about this practice? Who referred you?

Psychology Today LifeSpire website Friend/Relative Insurance Other: _____

Please list anyone living in the home with your child:

Name	Age	Relationship to you	Occupation

Briefly describe your concerns for your child and what brings you in:



DEVELOPMENTAL HISTORY

Did the mother experience any potentially serious health problems during pregnancy, such as high blood pressure, toxemia, RH incompatibility, measles, etc.? YES NO

Was your child born prematurely? YES NO

What was your child's weight at birth? _____ pounds _____ ounces

Did your child experience any difficulties at birth, such as breathing problems, oxygen deprivation, use of incubator, etc.? YES NO

Please check early, on time, or late in terms of developmental milestones of your child:

	<u>EARLY</u>	<u>ON TIME</u>	<u>LATE</u>
Sit up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toilet Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Education Grade Level: _____ Educational Placement: _____

Current School: _____

How would you describe your child with regard to academic performance?

GOOD AVERAGE POOR

Describe your child's religious or spiritual orientation? _____

Has your child ever been arrested or involved in litigation? _____

MENTAL HEALTH BACKGROUND OF CHILD

At this time, does your child have thoughts of self-harm? YES NO UNKNOWN

Has your child ever attempted suicide? YES NO UNKNOWN

At this time, does your child ever think of harming others? YES NO UNKNOWN



Please list any previous mental health treatment and/or substance abuse treatment:

Treatment Dates	Name of Provider/Agency	Reason for Treatment	Treatment Success

MEDICAL HISTORY

Name of Primary Care Physician or Provider: _____

Address: _____ Phone: _____

How would you describe your child's physical health?

- Excellent Good Average Poor Very Poor

List any of your child's medical conditions:

List any prescription or over-the-counter medications your child is taking:

Medication/Drug	Dose/Frequency	When started	For what symptoms

Does your child have any allergies or sensitivities to drugs, food, or other substances?

- YES NO

Does your child smoke or use other tobacco products?

- YES NO Unknown

Does your child use recreational drugs (marijuana, cocaine, or other drugs)?

- YES NO Unknown Unsure but suspect
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If there is any other information that you believe would be helpful for me to know, please describe below:

