CAMP HILL (Main Office/Billing Address)
207 House Ave, Suite 109
Camp Hill, PA 17011

LifeSpire, LLC
www.LifeSpirePA.com
717-745-6166

HERSHEY
523 W. Chocolate Ave, 2nd Floor
Hershey, PA 17033

Child Information Sheet

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

Address: _____

Home Phone: _____ ☐ **Cell/** ☐ **Work Phone:** _____

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

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

Parents' 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, then 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?

_____

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:

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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:

	EARLY	ON TIME	LATE
Sit up	☐	☐	☐
Crawl	☐	☐	☐
Talk	☐	☐	☐
Walk	☐	☐	☐
Toilet Training	☐	☐	☐

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: