Background Information

Child Form

Today's Date _____

Child's Name _____ DOB _____ Age _____
School Currently Attending _____ School Grade _____

Person Completing this Form _____
Relationship to Child _____ *(mother, father, legal guardian, self…)*

Who will bring this child to counseling? _____
Address: _____ City: _____ Zip: _____
Home Phone: _____ Cell Phone: _____

Mother's Name _____ Phone _____
Cell Phone _____ Occupation _____
Work Phone _____ Is it ok to call you at work? Yes No

Father's Name _____ Phone _____
Cell Phone _____ Occupation _____
Work Phone _____ Is it ok to call you at work? Yes No

Parental Status: Single Married Engaged Committed
Separated Divorced Widowed

How many siblings are there? _____ How many live at home? _____

Name _____ D.O.B. _____ Age _____ M / F
Name _____ D.O.B. _____ Age _____ M / F
Name _____ D.O.B. _____ Age _____ M / F
Name _____ D.O.B. _____ Age _____ M / F
Name _____ D.O.B. _____ Age _____ M / F

Who else lives in household?
Name_____ Age_____ Relationship_____
Name_____ Age_____ Relationship_____
Name_____ Age_____ Relationship_____
Name_____ Age_____ Relationship_____
Name_____ Age_____ Relationship_____

Briefly describe what brings you (your child) to counseling at this time _____
_____
_____
_____

How long has this been a concern for you? _____

_____

Please continue on the next page.

Child's Name _____

What have you tried in the past that has helped? _____
_____

Has this child received counseling services before? Yes No

If yes, what was the nature of the counseling? (Check all that apply)

- O Abuse or Neglect
- O ADHD
- O Anxiety or Phobia
- O Behavior Problems
- O Bipolar Disorder
- O Court- Ordered
- O Depression
- O Other _____
- O Parents Divorce or Separation
- O Grief or Loss
- O Life Change Adjustment
- O Obsession Compulsive Disorder
- O PDD, Aspergers, Autism
- O Substance Abuse
- O Trauma, PTSD

Is this child currently under the care of a physician or psychiatrist? Yes No
What medications are currently taken?

Medication	Dosage	Frequency	Symptoms/Diagnosis

Are there other mental or physical conditions that affect the functioning of this child?
Please describe: _____
_____
_____

Is there a history of mental illness in your family? Yes No If yes, by whom?
Mother Father Sibling Grandparent Aunt/Uncle
Cousin Spouse Child Partner Other
What is the nature of the mental illness? _____

Is there a history of substance abuse in your family? Yes No If yes, by whom?
Mother Father Sibling Grandparent Aunt/Uncle
Cousin Spouse Child Partner Other

Please include other information that may be helpful in my work with your child.
_____
_____
_____
_____
_____
_____