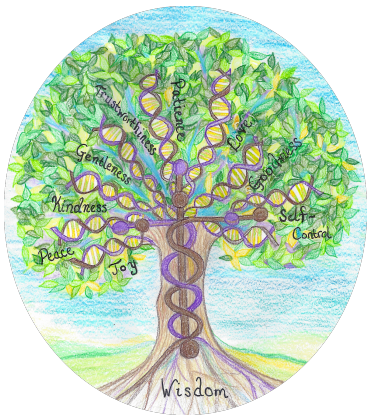

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Child Information Sheet

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

Address: _____

☐ **Father's Phone:** _____ ☐ **Mother's Phone**_____

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

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

Parents' Relationship Status (Circle)

Never Married Married Partnered Divorced Separated Widow/Widower

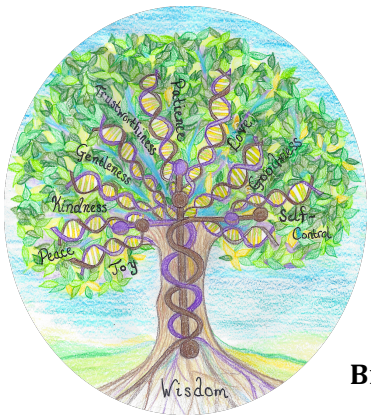
Court Ordered Custody Status (Circle) None Sole Legal Joint/Share Legal

(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 the child.

Name	Age	Relationship to Child	Occupation



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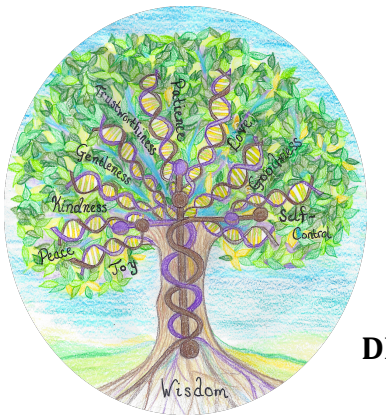
Briefly describe your concerns for your child and what brings you in:

_____

_____

_____

_____



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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.? (Circle) YES NO

Was your child born prematurely? (Circle) 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.? (Circle) YES NO

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

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

Education Grade Level:_____ Educational Placement: _____

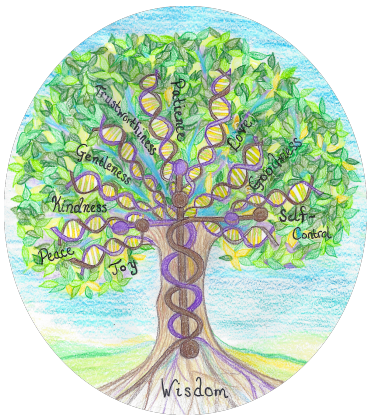
Current School: _____

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

GOOD AVERAGE POOR

Describe your child's religious or spiritual orientation? _____

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



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MENTAL HEALTH BACKGROUND OF CHILD

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

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

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

MEDICAL HISTORY

Name of Primary Care Physician or Provider (address/phone #): _____

_____

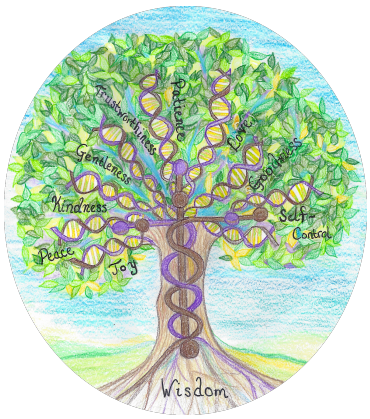
_____

How would you describe your child's physical health? (Circle)

Excellent Good Average Poor Very Poor

List any of your child's medical conditions: _____

_____



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List any prescription and 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? (Circle) YES NO

Does your child smoke or use other tobacco products? (Circle) YES NO UNKNOWN

Does your child drink alcohol? (Circle) YES NO UNKNOWN Unsure, but suspect

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

YES NO UNKNOWN Unsure, but suspect

If there is any other information that you believe would be helpful for me to know, please describe below:

_____

_____

_____

_____

_____