

# Interfaith Counseling Center

240 Rodes Avenue, Lexington, Kentucky 40508, Telephone: (859) 258-2060

## CLIENT INFORMATION FORM - CHILD FORM

Date: \_\_\_\_\_ File # (office use only) \_\_\_\_\_

This form is intended to save both you and your therapist time and is in the interest of providing you with the best service possible. All information on this form is considered confidential. If you do not wish to answer a question, please write, "Do not care to answer" after the question.

Child's Name \_\_\_\_\_ Nickname \_\_\_\_\_ Birthday \_\_\_\_\_ Age \_\_\_\_\_

Child's Social Security #: \_ \_ \_ - \_ \_ - \_ \_ \_ \_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Name of parent(s)/guardian at this address \_\_\_\_\_ Telephone \_\_\_\_\_

This parent's/guardian's occupation \_\_\_\_\_ Social Security #: \_ \_ \_ - \_ \_ - \_ \_ \_ \_

**MEDICAL DATA**

Family Physician: \_\_\_\_\_ Physician's Telephone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_ Date last seen: \_\_\_\_\_

When was the last time the child had a complete physical examination? \_\_\_\_\_

Has the child had the following? Please circle Y (yes) or N (no). If so, give the age when the illness occurred.

<u>Disease</u>	<u>Age</u>	<u>Disease</u>	<u>Age</u>
Chicken pox	Y/N _____	Earaches	Y/N _____
Scarlet fever	Y/N _____	Ear Discharge	Y/N _____
Whooping Cough	Y/N _____	Pneumonia	Y/N _____
3 day measles	Y/N _____	Influenza	Y/N _____
9 day measles	Y/N _____	Tonsillitis	Y/N _____
Mumps	Y/N _____	Arthritis	Y/N _____
Heart Disease	Y/N _____	Rheumatism	Y/N _____
Epileptic seizures	Y/N _____	Allergies	Y/N _____
Convulsion	Y/N _____	Meningitis	Y/N _____
Polio	Y/N _____	Glandular disorder	Y/N _____
Cerebral Palsy	Y/N _____	Fever (over 104)	Y/N _____
Paralysis	Y/N _____	Skin disorder	Y/N _____
Concussions	Y/N _____	Eye disorder	Y/N _____

Is child presently medicated? Y/N If yes, describe what medication, dosage, doctor, etc. \_\_\_\_\_

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Describe any neurological problems: \_\_\_\_\_

Describe any chronic or other handicapping condition: \_\_\_\_\_

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Has child had any of the following: If yes, please elaborate below:

Deformities: Y/N                  Accident: Y/N                  Operations: Y/N                  Prosthesis: Y/N

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DEVELOPMENTAL DATA

Prenatal and Birth:

Mother's condition during pregnancy: \_\_\_\_\_

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Accidents \_\_\_\_\_                  Illness \_\_\_\_\_

Length of pregnancy \_\_\_\_\_                  Length of labor \_\_\_\_\_

Type of delivery \_\_\_\_\_                  Child's weight \_\_\_\_\_

Condition of child after birth \_\_\_\_\_

Congenital abnormalities: Y/N                  Injury: Y/N                  Child in NICU: Y/N

Feeding problems: Y/N                  Breast: Y/N                  Bottle: Y/N

Sleeping problems: Y/N                  Skin conditions: Y/N

If yes to any of the above, please elaborate: \_\_\_\_\_

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Developmental milestones: At approximately what age did child begin

Crawling \_\_\_\_\_

Standing \_\_\_\_\_

Sitting \_\_\_\_\_

Teething \_\_\_\_\_

Solid foods \_\_\_\_\_

Feeding Self \_\_\_\_\_

Walking \_\_\_\_\_

Weaned \_\_\_\_\_

Talking (1 & 2 words) \_\_\_\_\_

Dressing self \_\_\_\_\_

Toilet trained \_\_\_\_\_

Describe the quality and quantity of the following (below, average, above):

Coordination - Fine motor \_\_\_\_\_

Gross motor \_\_\_\_\_

Height for age \_\_\_\_\_

Weight for age \_\_\_\_\_

Hand preferred: \_\_\_\_\_

Family handedness: \_\_\_\_\_

Tests and evaluations:	Date	By Whom	Where:
1. Physical	_____	_____	_____
2. EEG	_____	_____	_____
3. Psychological	_____	_____	_____
4. Speech & Language	_____	_____	_____
5. Audiometric	_____	_____	_____
6. Sensory Motor	_____	_____	_____
7. Adaptive Behavior	_____	_____	_____
8. Developmental Screen	_____	_____	_____

SCHOOL HISTORY:

Is your child in school? Y/N      Grade \_\_\_\_\_

Name of School \_\_\_\_\_ Phone \_\_\_\_\_

Address of school \_\_\_\_\_ Principal (Name) \_\_\_\_\_

Counselor (Name) \_\_\_\_\_ Teacher \_\_\_\_\_

Schools attended:

Nursery school?      Y/N      Where \_\_\_\_\_

Kindergarten?      Y/N      Where \_\_\_\_\_

Grade School?      Y/N      Where \_\_\_\_\_

Middle School?      Y/N      Where \_\_\_\_\_

High School?      Y/N      Where \_\_\_\_\_

What is child's attitude toward school? \_\_\_\_\_

Age entered first grade \_\_\_\_\_ Grades repeated \_\_\_\_\_

Grades skipped \_\_\_\_\_ Number of times child has changed schools \_\_\_\_\_

Best grades in \_\_\_\_\_

Poorest grades in \_\_\_\_\_

Average grade \_\_\_\_\_

FAMILY DATA

Please list all people living in the same household as the child, as well as any other parents or siblings in another household.

<u>Name</u>	<u>Age</u>	<u>Occupation/Education</u>	<u>Relationship</u>	<u>Living w/ child</u>
_____	_____	_____	_____	Y/N
_____	_____	_____	_____	Y/N
_____	_____	_____	_____	Y/N
_____	_____	_____	_____	Y/N
_____	_____	_____	_____	Y/N
_____	_____	_____	_____	Y/N
_____	_____	_____	_____	Y/N
_____	_____	_____	_____	Y/N
_____	_____	_____	_____	Y/N
_____	_____	_____	_____	Y/N

Parents' status: Unmarried \_\_\_\_\_; Married \_\_\_\_\_; Separated \_\_\_\_\_;  
Divorced \_\_\_\_\_; When? \_\_\_\_\_

Who has legal custody of child: \_\_\_\_\_ Child lives with: \_\_\_\_\_

Other parent's address and phone: \_\_\_\_\_

\_\_\_\_\_

In the past, has the child lived for any significant period of time with anyone other than the natural parents? Y/N If so, please describe the circumstances, the child's age at the time, and give that person's name and relationship to the child.

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Father's attitude toward child \_\_\_\_\_

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His discipline with child (generally) \_\_\_\_\_

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Mother's attitude toward child \_\_\_\_\_

Her discipline with child (generally) \_\_\_\_\_

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Parent's reaction to this pregnancy \_\_\_\_\_

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How did the pregnancy affect the family? \_\_\_\_\_

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Relationship of grandparents with child \_\_\_\_\_

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Relationship of stepparent(s) with child \_\_\_\_\_

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### PERSONALITY AND INTERESTS

Child's interests and hobbies \_\_\_\_\_

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How does child spend free time? \_\_\_\_\_

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What does child like to do if permitted to do whatever he/she likes? \_\_\_\_\_

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What kinds of things, persons, situations, or activities make your child happy? \_\_\_\_\_

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What kinds of things, persons, situations, or activities make your child upset, uncomfortable, tense, or depressed? \_\_\_\_\_

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Child's relationship style with siblings and peers \_\_\_\_\_

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Child's reaction to birth of siblings \_\_\_\_\_

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Does child like to play with others or would child rather play alone? \_\_\_\_\_

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Do others seek child out for play? \_\_\_\_\_

### PRESENT DIFFICULTIES

Please describe child's present difficulties:

Problem

When was problem first noticed? By whom?

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Which of these problems are you most concerned about? \_\_\_\_\_

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