

Confidential Child Information Form

Child Name:		
Child Age:		Date of Birth:
Child Ethnicity:	<input type="checkbox"/> African-American <input type="checkbox"/> Asian <input type="checkbox"/> More than one race	<input type="checkbox"/> American/Alaskan Indian <input type="checkbox"/> Latino/a <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Anglo <input type="checkbox"/> Other

Child Health History		
Primary Pediatrician's Name:		
Date of Last Appt:		Phone:
Address:		
City:	State:	Zip:
Please list any serious illnesses, surgeries, and medical problems that your child has ever had:		
Has your child ever experienced a severe blow to the head or loss of consciousness? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:		
Has your child had any traumas or exposure to violence? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:		
Describe at what age your child reached the following developmental milestones:		
Walking	_____	age
Crawling	_____	age
Talking	_____	age
Toilet training	_____	age
Additional information regarding your child's development:		
Is your child...? <input type="checkbox"/> Right handed <input type="checkbox"/> Left handed <input type="checkbox"/> Ambidextrous		

Please list any medications (prescribed and over-the-counter) that your child is <i>currently</i> taking:		
MEDICATION NAME	DOSAGE	FOR WHAT REASON?

Child Psychological History
Has your child ever seen a therapist or Psychiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dates:
If yes, for what concerns, and what was helpful or not helpful about this treatment?

Child School Information	
Name of school that your child is attending:	
Grade Level: <input type="text"/>	Estimated GPA: <input type="text"/>
Has your child ever been given an IEP (Independent Educational Plan) or any other type of Special learning service? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:	
Has your child ever had disciplinary action at school or have concerns been express by teachers? <input type="checkbox"/> Yes <input type="checkbox"/> No Dates: <input type="text"/> If yes, please explain:	

Child Social Information
Is your child involved in extracurricular activities? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what type and how often?
Is your child involved in athletics? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:
Describe your child's social interaction both in and out of school (Play dates, close friendships, school friends):
Describe your child have a favorite toy, television program or activity:
How often does your child engage in this activity:
For how long does your child engage in this activity?
Briefly explain why your child is seeking therapy at this time:
List any major changes or life events that have occurred for your child in the last two years:
Is there any additional information that would be important to know about your child:

Legal Guardian Name (Please print):			
Date:			
Legal Guardian Age:		Legal Guardian Date of Birth:	
Driver's License #:			
Parental Status: Description of relationship to the child:			
<input type="checkbox"/> Biological Parent	<input type="checkbox"/> Step-parent/co-parent	<input type="checkbox"/> Legal Guardian	
<input type="checkbox"/> Foster Parent	<input type="checkbox"/> Adoptive Parent	<input type="checkbox"/> Other:	
Home Address:			
City:	State:	Zip:	
Home Phone:		Cell Phone:	
Email:			
Employment Status:			
<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/> Unemployed			
Employer Name:			Job Title:
Spouse/Partner Employer Name:			Job Title:
Active Military: <input type="checkbox"/> Yes <input type="checkbox"/> No	Branch:	Date Entered:	
Rank:			
Time served overseas: <input type="checkbox"/> Yes <input type="checkbox"/> No		Time served in combat: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ethnicity:	<input type="checkbox"/> African-American	<input type="checkbox"/> American/Alaskan Indian	<input type="checkbox"/> Anglo
	<input type="checkbox"/> Asian	<input type="checkbox"/> Latino/a	<input type="checkbox"/> Other
	<input type="checkbox"/> More than one race	<input type="checkbox"/> Native Hawaiian/Pacific Islander	
Affectional/Sexual Orientation: <input type="checkbox"/> Heterosexual <input type="checkbox"/> Lesbian/Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Uncertain			
Religion:			
<input type="checkbox"/> Catholic	<input type="checkbox"/> Protestant	<input type="checkbox"/> Jewish	<input type="checkbox"/> Islamic
<input type="checkbox"/> Buddhist	<input type="checkbox"/> Hindu	<input type="checkbox"/> Christian	<input type="checkbox"/> Other:
Highest Level of Education Completed:			
<input type="checkbox"/> Some High School	<input type="checkbox"/> High School/GED		
<input type="checkbox"/> Some College	<input type="checkbox"/> Technical/Apprentice cert.		
<input type="checkbox"/> AA Degree	<input type="checkbox"/> BA/BS Degree		
<input type="checkbox"/> MA/MS Degree	<input type="checkbox"/> Md/JD/Doctoral Degree		

Please fill in the chart below regarding your <u>current living situation</u> (who lives in your home)				
FIRST NAME	AGE	ETHNICITY	OCCUPATION	RELATIONSHIP

Emergency Contact: Please identify an individual that we may contact in the event of an emergency.			
Name:		Relationship to you:	
Address:			
City:	State:	Zip:	
Home Phone:		Cell Phone:	

Person to be billed for fees:			
Name:		Relationship to you:	
Address:			
City:	State:	Zip:	
Home Phone:		Cell Phone:	
How did you hear about <i>Therapy Changes</i> ?			

Thank you for your time, and I look forward to meeting you soon!