

Date: _____

CHILD'S INFORMATION SHEET

1. Client's Name _____ DOB: _____ PLEASE CHECK BOX
 Address _____ SSN: _____ IF # CAN BE USED
 City _____ Zip _____ Phone (Home): _____ FOR CONTACT

2. Family information: Cell Phone: _____

Mother's Name _____ Phone (Home) _____

Employed by _____ Phone (Office): _____

Father's Name _____ Phone (Home) _____

Employed by _____ Phone (Office) _____

E-mail address: _____

** Responsible Parent's Drivers License # _____

African American/Asian-Oriental/Caucasian/Hispanic/Native American

Names and ages of others who reside with client _____

Emergency contact (other than spouse) _____

Relationship to client _____ Phone _____

3. Have you ever consulted with a mental health professional?

If so, whom? _____ When? _____

Did you provide history or records from that provider or facility? Yes/ No

4. Medical: Specify medication and dosages you currently take (use back if needed):

Any Drug Allergies: _____

Your physician _____ Physician's phone # _____

Underline any condition you have ever been treated for or had indications of:

A. High blood pressure, hypoglycemia, diabetes, anemia or any disorder of the blood

B. Fainting, convulsions, tension or migraine headaches, paralysis, epilepsy, memory loss or confusion, or any disorders of the brain or nervous system.

Please list any other relevant medical condition not already listed:

Were there any complications with the client's birth, if so what happened:

Underline any **recent changes** (last six months) in your:

- 1) vision, hearing, coordination, balance, strength, speech, memory or thinking;
- 2) changes in energy, sleeping, eating, elimination, menstrual cycle, sexual activity.

Last physical exam date: _____ Height: _____ Weight: _____

Check any condition you have ever been treated for or had indications of. Check all that apply. Go back and **circle** any **present** conditions.

Sleep problems	Yes__ No__	Eating disorder	Yes__ No__
Appetite change	Yes__ No__	Weight gain/loss	Yes__ No__
Hyperactivity	Yes__ No__	Mood Swings	Yes__ No__
Anxiety	Yes__ No__	Depression	Yes__ No__
Difficulty concentrating	Yes__ No__	Memory loss	Yes__ No__
Confusion	Yes__ No__	Arguments	Yes__ No__
Marital Conflict	Yes__ No__	Family Conflict	Yes__ No__
Sexual problems	Yes__ No__	Sexual abuse	Yes__ No__
Physical abuse	Yes__ No__	Suicidal thoughts	Yes__ No__
Suicide attempts	Yes__ No__	Hallucinations	Yes__ No__
Head Injury	Yes__ No__	Seizures	Yes__ No__
Chronic Pain	Yes__ No__		

Drug and Alcohol History:

Drug use/abuse	Yes__ No__	DUI or PD Charge	Yes__ No__
Tobacco use	Yes__ No__	Alcohol use/abuse	Yes__ No__

If you answered yes to the above set of questions, please state how much, how often and what period of time:

Do you have any special needs or concerns(e.g. language barriers, disabilities):

Briefly describe in your own words your reasons for seeking help at this time:

Signature _____ Date _____