



Karen Sullivan, LCSW

Child Client Information Form

Today's date: _____

A. Client's Information

Child's name: _____ Date of birth: _____ Age: ____ Grade: ____ Gender: __
Nicknames or aliases: _____ Social Security #: _____

B. Parent 1 Information

Parent 1 name: _____ Date of Birth: _____
Employer: _____ Occupation: _____ Highest Level of Education: _____
Address: _____
*Email: _____
Calls will be discreet, but please indicate any restrictions: _____

Numbers	Voice Mail Ok?	Text Ok?
Home:		
Cell:		
Work:		

C. Parent 2 Information

Parent 2 name: _____ Date of Birth: _____
Employer: _____ Occupation: _____ Highest Level of Education: _____
Address: _____
*Email: _____
Calls will be discreet, but please indicate any restrictions: _____

Numbers	Voice Mail Ok?	Text Ok?
Home:		
Cell:		
Work:		

D. Appointment Reminders

How would you like to be reminded of appointments? Choose one or both.

Text: _____ *Email: _____

E. Referral

Who referred you to my office?

Name: _____ Phone: _____

Address: _____

May I have your permission to thank this person for the referral? ___ Yes ___ No

How did this person explain how I might be of help to you? _____

*Karen Sullivan cannot guarantee the privacy of communication via email. By placing your email in the blanks above, you acknowledge the limitations of privacy and agree that Karen Sullivan may use email to correspond with you.

F. Child's medical care

From whom or where does your child get his/her medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

If your child enters treatment with me for therapy, may I tell his/her medical doctor so that he/she can be fully informed and we can coordinate your child's treatment? Yes No

In the event of an emergency, may I contact your child's medical doctor and disclose necessary information so that he/ she can be fully informed and we can coordinate your child's treatment? Yes No

G. Parents' Marital Status

Are the child's parents: Married _____ Divorced _____ Never Married _____

If the parents are divorced, give the month and year the divorce was granted _____

Are both parents named as Joint Managing Conservators in the Divorce Decree? Yes No

Does either parent have primary physical custody of the child? Yes No

With whom does the child currently live? _____

Is either parent remarried? If so, please explain. _____

Have either parent's parental rights been terminated by a court? Yes No

Have either parent's rights to consent to treatment or obtain records of treatment been limited or restricted by a Court Order? Yes No If the answer is "Yes," please explain: _____

NOTE: A COPY OF THE PARENTS' DIVORCE DECREE OR APPLICABLE COURT ORDER MUST BE PROVIDED BEFORE ANY SESSIONS WITH THE CHILD WILL BE SCHEDULED .

H. Family Members (list those living in home with your child)

Name	Age	Sex	Grade	Relationship to child
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

I. People with significant relationships to child (list those NOT living in the home with your child)

Name	Relationship to child
_____	_____
_____	_____
_____	_____

J. Family Stressors in the past year

- Death of family member or significant other
- Family fighting or conflict
- Marital problems, divorce or separation
- Involvement with police or court system
- Change in financial status, more or less income
- Other significant events: _____
- Serious illness or injury
- Move to new home
- Change in job
- Move to new home
- Childrearing problems

K. Family Mental Health History

Have any family members (immediate or extended) struggled with the following?

- Depression
- Bipolar
- Autism
- Anxiety
- Substance abuse
- Domestic violence
- Suicide or attempts
- Eating disorders
- Incarceration
- Obsessive-Compulsive Disorder

___ Abuse/neglect

___ Schizophrenia

L. Medications

Name of Medication?	Dosage/Mg?	Frequency?

M. Any problems or concerns about your child’s medications? ___ Yes ___ No

(If yes have you talked to the prescribing physician? _____)

N. Emergency Contacts:

List the name(s) of the person(s) who may be contacted by this office in the event of an emergency involving your child. Please be aware that the person(s) listed may receive information in an emergency situation that would otherwise be confidential by law. By listing the name(s) below, you give this office permission to contact the person(s) listed and provide necessary information about your child in the event of an emergency.

O. Chief Concern(s): Please describe the main difficulty that has brought your child to see me:

P. Goal for Therapy

What are your goals for therapy or what changes would you like to see in your child?

Q. Current Symptoms

Check any areas in which your child is having problems:

Anxiety, worry	Nervous habits
Appetite changes	Nightmares, sleeping difficulties
Argumentative, talks back	Noncompliance
Attention seeking	Obesity
Bullies others	Panic attacks
Complains of feeling sick	Poor hygiene
Conflict with parents or other adults	Poor peer relationships
Cries easily	Poor sibling relationships
Cruel to animals	Promiscuity
Defiant, oppositional behavior	Risk-taking behaviors, poor judgment
Drug or alcohol use	Runs away
Fighting, aggressive	Sad, unhappy
Fire setting	School truancy
Friends are significantly older or younger	Self-harming behaviors
Hyperactive	Separation anxiety
Imaginary playmates	Sexual acting out
Impulsive	Short attention span
Lack of assertiveness	Social isolation
Lack of respect for authority	Suicidal talk, thoughts, or attempts
Lethargic, slow-moving	Temper tantrums
Low frustration tolerance	Tics, involuntary movements or noises

Lying	Uncoordinated
Moody	Unorganized
Mute, refuses to speak	Wetting or soiling bed or clothes
Other:	

R. Has your child ever received counseling services before? No Yes. If yes,
 When? With Whom? For What? With What results?

S. Trauma History?

My child was not abused in any way. My child was abused (sexual, physical, emotional, neglect)

If your child were abused:

Age of Abuse Who did it? Whom did you tell? Consequences of telling?

My child has had significant losses. Explain circumstances: _____

My child has experienced natural disasters. Explain circumstances: _____

My child has been exposed to violence. Explain circumstances: _____

T. Child Developmental History:

1. Pregnancy and delivery: normal caesarian breech premature other complications

2. The first few years of life: Breast-fed? _____ If so, for how long? _____ Any allergies? _____

Sleep patterns or medical problems: _____

3. Milestones: At what age did this child do each of these?

Sat without support Crawled Walked without holding on

Helped when being dressed Ate with a fork Stayed dry all day

Didn't soil his/her pants Stayed dry all night Dressed self completely

4. Speech/language development

Age when child said first word understandable to strangers: _____

Age when child said first sentence understandable to a stranger: _____

Any speech, hearing, or language difficulties? _____

U. Health

List all childhood illnesses, hospitalizations, medications, allergies, head trauma, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition Age Treated by whom? Consequences?

V. Residences

Outside your home? (Examples would be Foster Care, Residential Placement, etc) No Yes (If yes please complete below):

From To Location Reason for moving With whom Any problems?

W. Schools

School (Name, district, address, phone)

Grade

Age

Teacher

Any concerns about progress in school? Yes No If yes, please list : _____
