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. Mother's Information
Mother's 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. Father's Information
Father's 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:_____

_____

_____

<u>NOTE</u>: 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
___ Abuse/neglect
___ Domestic violence
___ Suicide or attempts
___ Eating disorders
___ Incarceration
___ Obsessive-Compulsive Disorder
___ 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 chld 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 :_____
_____