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Client Information Sheet – Child

Name of Child _____ Date of Birth _____

_____ Male _____ Female Age _____ years

Street Address _____ City _____ Zip Code _____

Home Phone _____ Child Resides With _____

Parent 1 Name _____ Relationship to Child _____

Employer _____ Occupation _____ # Years ____

Work Phone _____ Cell Phone _____

Email Address _____ Preferred Method of Contact _____

Parent 2 Name _____ Relationship to Child _____

Employer _____ Occupation _____ # Years ____

Work Phone _____ Cell Phone _____

Email Address _____ Preferred Method of Contact _____

In Case of Emergency Contact _____ Phone Number _____

Relationship to Child _____

How did you hear about Ensemble Therapy? _____

Do I have your permission to thank the referral source for referring you? _____

Do you give this office consent to mail information/newsletters to your home address? _____

Family Profile & Social History

Parent's Marital Status (Please check current status)

_____ Married (Date: _____) _____ Divorced (Date: _____)

_____ Separated (Date: _____) _____ Widowed (Date: _____)

_____ Never Married _____ Domestic Partners

Please briefly describe any significant conflicts between the parents _____

_____

Divorce Decree **If the child's parents are divorced then a copy of the complete divorce decree MUST be provided to Ensemble Therapy before the family will receive services.**

Who currently has legal custody of the child? _____

Have either parent's rights been terminated by a court? _____

Have either parent's rights to consent to treatment or obtain records of treatment been limited or restricted by a Court Order? _____

If the answer is "yes" then please explain _____

_____

If separated/divorced, how often does this child spend time with each parent? _____

_____

Please list everyone (siblings, relatives, blended family members, etc.) currently living in the household:

Name	Age	Gender	Employment/School	Relationship to Child

Developmental History

MOTHER'S PREGNANCY

Was the child adopted? _____ If yes, at what age? _____ From what country? _____

Please list what is known about care received before adoption _____

_____

_____

Did the child's mother experience any of the following?

____ Complications	____ Serious Illness
____ Premature Delivery	____ High Blood Pressure
____ Alcohol/Drug Use	____ Diabetes
____ Anemia	____ Depression
____ Smoking	____ Take Medications

Length of pregnancy _____ Child's Weight at Birth _____

Were there any problems during labor and/or delivery? If yes, please explain. _____

_____

_____

_____

_____

Did the child have any problems at birth? If yes, please explain. _____

_____

_____

_____

_____

EARLY DEVELOPMENT

Child's First Language _____ If not English, what age did the child learn English? _____

Were any of the following present during your child's early childhood?

____ Did not enjoy cuddling ____ Difficult to comfort ____ Colic ____ Irritability

____ Eating difficulties ____ Excessive sleep ____ Head banging ____ Seizures

____ Difficulty sleeping ____Demanding/Clingy ____ Developmental delays ____ Ear infections

____ Emotional responsiveness ____ Other: _____

At what age did your child do the following? (Please estimate)

____ Smile ____ Say first words ____ Sit without help ____ Crawl

____ Speak in sentences ____ Completely weaned ____ Walk without support ____ Potty trained

MEDICAL HISTORY

Please describe any childhood illnesses. _____

_____

Hospitalizations/Operations? _____

_____

Does your child have a history of any of the following?

____ Allergies (not drugs) ____ Anemia ____ Arthritis ____ Asthma

____ Blood transfusion ____ Cancer/tumor ____ Chicken pox ____ Depression

____ Diabetes ____ Drug/Alcohol use ____ Ear infections ____ Eating disorder

____ Eczema or psoriasis ____ Epilepsy/Seizures ____ Headaches ____ Hearing loss

____ Heart problems ____ Heart murmur ____ High blood pressure ____ HIV or AIDS

____ Hyper/Hypo-thyroid ____ Inherited disease ____ Kidney disease or stone ____ Lung disease

____ Measles ____ Pneumonia ____ STD ____ Sickle cell anemia

____ Strep throat ____ Tuberculosis ____ Vision problems ____ Whooping cough

Present Medical Conditions/Concerns _____

Current Medications _____

Reason(s) for medications _____

Doctor Prescribing _____ Office Phone _____

Current Physician (if different from above) _____ Office Phone _____

Date of last Physical Exam _____ Are immunizations current? _____

Has your child ever had a psychological/psychiatric evaluation? If yes, when and by whom? _____

_____

Has your child ever been hospitalized for emotional or behavioral reasons? If yes, when, where, and how long?

_____

Does your child have any developmental or other disabilities? If yes, please explain and list any specific accommodations needed.

_____

_____

EDUCATIONAL HISTORY

School/Daycare presently attending _____ Grade _____

Has your child ever repeated a grade? If yes, which one? _____

Is your child in special education? If yes, please identify condition. _____

_____

Number of schools attended: _____ Elementary School _____ Middle/Junior HS _____ High School

Please describe any academic issues your child has. (For example, grades, test taking, homework habits) _____

_____

Please describe any school behaviors you're concerned about. (For example, what you hear in teacher conferences)

_____

_____

Please describe your child's relationships at school with teachers, authority figures, peers, etc. _____

_____

_____

_____

Reason for Seeking Services

Please identify any stressors that your child may have experienced or witnessed. Check all that apply.

_____ Death	_____ Separation	_____ Divorce	_____ Marital Conflict	_____ Moving
_____ Financial	_____ Abuse	_____ Car Accident	_____ Natural Disaster	_____ Bullying
_____ Illness	_____ Arrest	_____ Terrorism	_____ Serious Injury	_____ Drugs
_____ Domestic Violence	_____ Mental Health Issue	_____ Grief over loss	_____ Other: _____	

Has your child experienced abuse? _____ If yes, has this been reported? _____

Please explain. _____

_____

Describe any traumatic experience(s) and how these have impacted your child. _____

_____

_____

_____

Please describe the main difficulty that has brought your child for treatment. _____

_____

_____

_____

Do you have any concerns about your child inflicting harm to self or others? _____ If yes, please explain.

_____

_____

Briefly tell me about your child. What is he/she like? What are his/her strengths? Tell me what you love about your child.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____