



New Client Information: Child

(To be completed by Parent or Guardian)

Child's Name _____ Date of Birth _____
First Middle Last

Gender Male Female School _____ Teacher _____ Grade _____

Address: _____

Name of parent or guardian with whom child lives _____ Home Phone Number _____

Pediatrician _____ Pediatrician Phone Number _____

Describe the behaviors or emotions exhibited by the child that concern you:

When did you first notice these problems?

Why do you think your child shows these emotions or behaviors?

What would you rather see your child doing instead?

When do you see your child happy and behaving in a positive way?

FAMILY DATA

Mother's Name _____ Occupation _____

Employer _____ Work Phone Number (Optional) _____

Mother's Work Schedule _____

Father's Name _____ Occupation _____

Employer _____ Work Phone Number (Optional) _____

Father's Work Schedule _____

Step-parent's Name _____ Occupation _____

Employer _____ Work Phone Number (Optional) _____

Marital Status of Parents _____

If parents are separated or divorced, how old was child when the separation occurred? _____

Recent Traumatic Events _____

Ages of Brothers and Sisters living in the home: Brothers _____ Sisters _____

List other individuals living in the home _____

Describe the room in which your child resides: _____ Single Room _____ Shares Room with _____

Does custodial parent work outside the home? _____

If yes, who is the primary caregiver when the parent(s) is away? _____

What are the child's responsibilities at home? _____

Does your child have difficulty making friends? _____

How does he/she get along with the children in the neighborhood? _____

Describe his/her relationship with other children in the family: _____

Does your family participate in religious services? _____ If yes, what type? _____

In what activities does the family participate as a family unit? _____

Are there any family problems that may be contributing to the child's present difficulties? _____

Does anyone in the family have any of these concerns (i.e., Mom, Dad, Grandparents, Aunts, Uncles, Cousins)

Anxiety _____ Depression _____ ADD/ADHD _____
Bipolar Disorder _____ Schizophrenia _____ Obsessions/Compulsions (OCD) _____
Suicide _____ Learning Problems _____ Mental Retardation _____
Eating Disorder _____ Anger Problems _____ Autism/Asperger's Disorder _____
Substance Abuse/Alcohol Abuse _____ Other _____

SCHOOL HISTORY

What grade(s) has your child repeated? _____ Please List Other Schools Attended _____

What are your child's best subjects? _____

Worst subjects? _____

If your child is experiencing a problem, what do you perceive the problem to be? _____

When was it first noticed? _____ What is his/her attitude toward school? _____

Describe your child's study habits at home _____

Who is the primary person who helps with homework? _____

How much time is spent on homework each night? _____

Has your child passed state assessment tests like the PSSA? _____

BIRTH HISTORY

List any illnesses or accidents occurring during pregnancy _____

Full Term: Yes No Birth Weight _____

Delivery: Normal Breech Cesarean

Did any of the following occur during pregnancy:

_____ Tobacco Use _____ Alcohol Use _____ Other Drugs or Substances

_____ Gestational Diabetes _____ Prescribed Medications _____ Anemia or Toxemia
_____ Elevated Blood Pressure _____ Injury or Accident _____ Emotional Trauma
_____ Domestic Violence

Was there any evidence of injury at birth? Yes No

If yes, please explain: _____

Were any of the following experienced before the child's second birthday?

_____ Feeding problems _____ Seizures/Convulsions _____ High fever
_____ Fainting _____ Serious accidents _____ Head injuries

Please give additional information on any item checked above: _____

DEVELOPMENTAL DATA

Does your child have a history of ear infections? Yes No

At what age did each of the following behaviors first occur?

_____ Crawling _____ Sitting Up _____ Fed Self _____ Walking Alone
_____ Dressed Self _____ Toilet Trained During Day
_____ Speaking first words besides "Ma-Ma" and "Da-Da"
_____ Tied Shoes
_____ Speech was clearly understood by others outside the family

Characteristics of child temperament in infancy/early childhood:

_____ Good Natured _____ Sluggish _____ Irritable _____ Active
_____ Resistant to touch _____ Cuddly _____ Easily Soothed _____ Affectionate
_____ Anxious _____ Clinging _____ Difficulty Separating _____ Shy or Timid

Has your child ever experienced or witnessed any physical abuse, domestic violence, sexual abuse, emotional abuse, or neglect?

Are you aware of or suspect that your child has ever used tobacco, alcohol, or drugs? No Yes (explain)

PHYSICAL CONDITION

Do you notice, or has a doctor reported, any of the following in this child:

Serious medical problems: _____

Serious Injury: _____

Childhood Diseases: _____

Seizures: _____

Hospitalization: _____

Allergies: _____

Date of last physical examination: _____

Please list Medications Prescribed and Dosages: _____

Date of last hearing and vision screening: _____

Agencies or specialists that have worked with your child:

_____ Mental Health Clinic	_____ Family Physician	_____ Social Worker
_____ Psychologist	_____ Psychiatrist	_____ Department of Human Service (DHS)
_____ Department of Juvenile Justice (probation officer)		

If checked, please give the following information:

NAME	TITLE	DATES
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child had any mental health hospitalizations?

HOSPITAL	DATES	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____

My child's general condition is:

- | | | |
|--|---|--|
| <input type="checkbox"/> Seems to be in good health | <input type="checkbox"/> Tires easily, listless, lacks energy | <input type="checkbox"/> Overweight |
| <input type="checkbox"/> Sleeps too much | <input type="checkbox"/> Underweight | <input type="checkbox"/> Sleeps too little |
| <input type="checkbox"/> Overly active, always on the move | | <input type="checkbox"/> Awkward in running, walking, or playing |

BEHAVIORAL CHECKLIST

(Please check the behaviors that best describe your child)

- | | | |
|--|---|--|
| <input type="checkbox"/> Feels happy with him/herself | <input type="checkbox"/> Sucks his/her thumb | <input type="checkbox"/> Demands excessive attention |
| <input type="checkbox"/> Overly dependent on others | <input type="checkbox"/> Wets the bed | <input type="checkbox"/> Plays well with other students |
| <input type="checkbox"/> Overly anxious to please | <input type="checkbox"/> Cries often | <input type="checkbox"/> Exhibits uncooperative attitude |
| <input type="checkbox"/> Tries to control others | <input type="checkbox"/> Poor self-control | <input type="checkbox"/> Has very few close friends |
| <input type="checkbox"/> Relates well to adults | <input type="checkbox"/> Friendly | <input type="checkbox"/> Lacks motivation, lazy |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Sad or depressed often | <input type="checkbox"/> Does not adjust readily to change |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Shy, withdrawn | <input type="checkbox"/> Acts younger than other children of age |
| <input type="checkbox"/> Openly affectionate to family | <input type="checkbox"/> Daydreams often | <input type="checkbox"/> Restless |

