STARKVILLE COUNSELING
ASSOCIATES

Child Information Form

Today's Date: _____ Completed by: ____Mother ____Father ____Other_____

Child's Name: _____Preferred Name_____ Date of Birth: _____

Parent(s)/Legal Guardian(s) (subject to proof): _____

Parents Relationship Status: __Married __Never Married __Separated __Divorced __Partnered __Widowed

If divorcing/divorced, or not a biological parent, LEGAL DOCUMENTATION OF CUSTODY/GUARDIANSHIP is required. Should this status change, it is your responsibility to provide SCA with current legal documents.

Siblings (including step-siblings and half-siblings):

Name	Age	Gender
1.		
2.		
3.		
4.		

Others in home (grandparents, cousins, family friends):

Name	Age	Gender
1.		
2.		
3.		
4.		

Significant Life Events in the Last Two Years

- Death of a loved one
- Move/School change
- Financial Problems for the family
- Parental remarriage/new step-siblings
- Birth of a new sibling
- Trauma (violence, natural disaster, car accident, etc. _____)
- Medical problems for any family members
- Legal problems for the family (assault, DUI, etc.)
- Divorce/Seperation
- Other_____

Child's Strengths or Abilities

- Academics/Grades
- Group Involvement (clubs, organizations)
- Sense of humor
- Sports
- Care for others
- Creative (art, music, etc.)
- Religious involvement

Other: _____

_____

Current Concerns about Your Child:

- Behavior at home/school
- Suicidal thoughts
- Anger/Irritability
- Health
- Sensitive to touch, sound, light, motion
- Mood
- Eating
- Sleeping
- Academic performance
- Difficulty paying attention
- Peer relationships
- Drugs/alcohol
- Sexual behavior
- Frequent worries/shyness

Comments:

_____

_____

_____

Is there a history of any previous treatment or any evaluations: __Yes __No

If so, when and by whom?

- Educational evaluation: _____
- Psychological evaluation: _____
- Outpatient therapy: _____
- Hospitalization(s): _____

Does your child take medication? __Yes __No

If so, please list medications(s) and dosage(s):

_____

_____

Who is the prescribing physician? _____

Child's Medical History

- Medical problems during pregnancy
- Maternal drug or alcohol use during pregnancy
- Premature birth (if so, weight at birth: _____ gestational age: _____)
- Complications during birth (ex. Emergency C-section, low oxygen, etc.)
- Stayed in neonatal intensive care (if so, how long? _____)
- Health problems as a newborn or toddler
- Frequent ear infections
- Asthma or allergies
- Head injuries/concussion/seizures/fevers over 104 degrees
- Serious accidents/hospitalizations
- Surgeries
- Problems with eating or sleeping

Child's Physician _____

Comments: _____

_____

Child's Developmental History

Problems with?
____ Sitting up ___ Walking ___Talking ___Toileting _____Bedwetting
____ Writing or using scissors ____ Reading or letter identification ___ Physical coordination (running, jumping, climbing)
___ Responding to discipline or behavior management ___Anger/temper tantrums ___ Fears ___ Sexual Play

Other: _____

_____

Child's Academic History

Current School: _____

School location: _____

Teacher: _____ Grade: _____
Has your child?

- Repeated a grade
- Skipped school
- Been suspended
- Been expelled
- Stopped doing homework
- Been bullied by others
- Been aggressive at school
- Received a IEP or 504
- Received any special services (OT, PT, Speech, etc.)

Child's Social Relationships

Does your child have a friend or friends outside the family? ___ Yes ___ No
Do you know them? ___ Yes ___ No
Do his/her friends tend to be: ___ older ___ younger ___ about the same age as your child
How well does your child get along with others?

_____

_____

Family History

Has anyone in your family struggled with (treated or untreated):

- Depression or Bipolar Disorder
- Anxiety
- Learning problems (reading, math, spelling)
- Attention problems
- Excessive alcohol or drug use
- Sexual abuse
- Physical abuse
- Suicide attempts or completed suicide

Do you have any other concerns about your child?

_____

_____

_____

How may I help? In your words, what brings you and your child to therapy?

_____

_____

_____

What are your 2 most important goals in therapy?

1. _____
2. _____

If you were to ask your child what his/her 2 most important goals in therapy (or 2 things they would like to change the most) were, what do you think they would be?

1. _____
2. _____

Thank you for taking the time to fill out this information sheet. This will be reviewed with you during the first session.