Child Information Form

Client's Name:____ Date of Birth: ___________________
Mailing Address: ____
Home Phone #: ___________________ Cell Phone #: ____________________ Work Phone #: _______________
Email: ____
Grade: _____________________ School: ____

Social

Family Members Living in Home:

Name | Relationship | Age
____
____
____
____
____

Parents/Siblings Not Living in the Home:

Name | Relationship | Age
____
____
____

What is the primary language spoken in the home? ____

Has your child ever received therapy or had a previous psychological or educational evaluation? If yes, by whom and when: ____
____

Has your child ever been involved with any outside agencies such as DFS, PBH, Rockford Center, and/or Terry Center? If yes, please list: ____
____
____

Health

List any medications that your child is currently taking:

Name of Medication | Dosage
____
____
____

Please check all that apply to your child. For those checked, please the age at which it occurred or began.

____Hearing problems
____Asthma
____Cancer
____Cystic Fibrosis
____Digestive Problems
____Frequent Ear Infections
____Heart problems
____Encopresis
____Migraines
____Emotional/Behavioral Problems
____Sleep Disorders
____Vision Problems
____Allergies
____Cerebral Palsy
____Coma
____Diabetes
____Frequent High Fevers
____Head Injury
____Enuresis
____Measles
____Fetal Alcohol Syndrome
____Other
____Headaches
____Stomachaches

Developmental and Educational

Please check any area where your child had significant difficulties/delays as an infant and/or toddler
____Feeding ____Weight ____Motor Skills ____Being Held ____Speech
____Excessive Crying ____Temper Tantrums ____Separating from Parents/Caregiver

Does your child currently have an IEP and/or 504 Plan at school? If yes, please list: ________________________________
____

Do you have any concerns about your child academically? If yes, please list: ______________________________________
____

How do you correct inappropriate behaviors in your child? ____
____

How do you reward/reinforce appropriate behaviors in your child? ____
____

What are your child's strengths? ____
____
____

Please list any additional information that may be helpful in getting to know your child and family: ___________________
____
____
____
____

Behavioral

Check the symptoms that have occurred in the past six months.

	Never	Some-times	Often	Very Often
Often loses personal items				
Doesn't pay attention to details on homework				
Has trouble getting organized				
Lines up objects rather than playing with them				
Doesn't play well with other children				
Has trouble sharing with other children				
Has trouble playing quiet activities				
Has trouble making friends				
Has trouble transitioning from one activity to the next				
Gets overly excited or stressed, even at fun occasions (parties, park, etc.)				
React to sounds, touch, or light				
Grades has decreased				
Frequent calls home from school				
Shows little interest in spending time with friends				
Fights with other children				
If fearful of going to school				
Is easily frustrated				
Has temper tantrums				
Becomes anxious or worried often				
Seems sad, lonely, or depressed				
Says he/she feels worthless or inferior				
Has rituals that need to be completed in order to feel okay				
Destroys property or objects				
Has set fires deliberately				
Is physically cruel to others				
Is physically cruel to animals				
Has run away from home overnight				
Fidgets with objects, hands, or feet				
Has difficulty waiting his/her turn				
Has difficulty sitting still				
Interrupts others conversations				
Is angry				
Is impulsive				
Doesn't like to be touched				
Argues with those in authority				

Completed by: ____Date: ____

Parent/Guardian Signature: ____

Therapists Signature: ____