

Oben Health Services LLC

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Client Information - Child

Today's date: _____

Note: If you have been a patient here before, please fill in only the information that has changed.

A. Identification

Your child's name: _____ Date of birth: _____ Age: _____

Nicknames or aliases: _____ Social Security #: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ e-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

B. Referral: Who gave you my name to call?

Name/Organization: _____

C. Religious and racial/ethnic identification

Current religious denomination/affiliation Protestant Catholic Jewish Islamic Buddhist Hindu

Other (specify): _____

Involvement: None Some/irregular Active

How important are spiritual concerns in your life? _____

Which (if any) church, synagogue, temple, or meeting are you involved with? _____

Ethnicity/national origin: _____ Race: _____ or other similar way
you identify yourself and consider important: _____

D. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

E. Insurance information

Policy holder's name (if different from patient): _____

Policy holder's date of birth: _____ Policy holder's ID/SS #: _____

Policy holder's employer: _____

Name of Insurance: _____

Insurance customer service phone number on card: _____

Policy #: _____ Group #: _____

F. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

Address: _____

Significant other/nearest friend or relative not residing with you: _____

G. Your child's education and training

Dates		Schools	Special classes? Adjustment to school	Did you graduate?
From	To			

H. Employment and military experiences

Dates		Name of employers	Job title or duties	Reason for leaving
From	To			

I. Family-of-origin history

Relative	Name	Current age (or age at death)	Illnesses (or cause of death, if deceased)	Education	Occupation
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Father

Mother

Brothers

Sisters

Stepparents

Grandparents

Uncles/aunts

Client Information (cont.)

Note: If you were a patient here before, please fill in only the information that has changed.

A. Identification

Name: _____ Date: _____

B. Chief concern

Please describe the main difficulty that has brought you to see me: _____

C. Treatment

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

No Yes If yes, please indicate:

When?	From whom?	For what?	With what results?
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2. Have you ever taken medications for psychiatric or emotional problems? No Yes If yes, please indicate:

When?	From whom?	Which medications?	For what?	With what results?
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D. Relationships in your family of origin.

Please describe the following:

1. Your parents' relationship with each other: _____

2. Your relationship with each parent and with any other adults present: _____

3. Your parents' medical problems, drug or alcohol use, and mental or emotional difficulties: _____

4. Your relationship with your brothers and sisters, in the past and present: _____

Child Developmental History Record

A. Development

Please fill in any information you have on the areas listed below.

1. Pregnancy and delivery

Prenatal medical illnesses and health care: _____

Was the child premature? No Yes. Weight and height at birth: _____ pounds _____ inches

Any birth complications or problems? _____

2. The first few months of life

Breast-fed? If so, for how long? Any allergies? _____

Sleep patterns or problems: _____

Personality: _____

3. Milestones: At what age did this child do each of these?

Sat without support: _____ Crawled: _____ Walked without holding on: _____

Helped when being dressed: _____ Tied shoelaces: _____ Buttoned buttons: _____

Ate with a fork: _____

Stayed dry all day: _____ Didn't soil his or her pants: _____ Stayed dry all night: _____

4. Speech/language development

Age when child said first word understandable to a stranger: _____

Age when child said first sentence understandable to a stranger: _____

Any speech, hearing, or language difficulties? _____

C. Health

List all childhood illnesses, hospitalizations, medications, allergies, head injuries, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?	Consequences?
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F. Special skills or talents of child

List hobbies, sports; recreational, musical, TV, and toy preferences; etc.: _____

G. Other

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important?

