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# Client Information

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

**H. Employment and military experiences**

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

**I. Family-of-origin history**

| Relative | Name | Current age (or age at death) | Illnesses (or cause of death, if deceased) | Education | Occupation |
|---|---|---|---|---|---|
| Father | | | | | |
| Mother | | | | | |
| Brothers | | | | | |
| Sisters | | | | | |
| Stepparents | | | | | |
| Grandparents | | | | | |
| Uncles/aunts | | | | | |

*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?

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?

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? |
|---|---|---|---|

## 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?

_____

_____

_____