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# Client Information Form (Child & Adolescent)

**Date:**_____

## Client

Name:_____
Last First Middle
Date of Birth:_____Age:_____SSN (for insurance billing):_____

Home Address: _____
Street Apt. Number
_____
City State Zip
Home (____)_____; Cell (____)_____; E-Mail:_____

Form Completed By:_____Relationship to Client:_____

## Involved Parents

### *Birth Mother*

Name: _____Occupation:_____
Date of Birth: _____Age:_____SSN (for insurance billing):_____
Home Address & Phone Number (if different from client's):
_____
_____
Name of Employer, Address, Phone Number:
_____
_____

### *Birth Father*

Name: _____Occupation:_____
Date of Birth: _____Age:_____SSN (for insurance billing):_____
Home Address & Phone Number (if different from client's):
_____
_____
Name of Employer, Address, Phone Number:
_____
_____

### ***Other Primary Parents*** *if different from or in addition to above*

Name(s):_____Occupation:_____
Date of Birth: _____Age:_____SSN (for insurance billing)_____
Home Address & Phone Number (if different from client's):
_____
_____
Name of Employer, Address, Phone Number:
_____
_____

## Others Living in the Home

| Name | Date of Birth | School | Grade | Relationship to Client |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

How were you referred to Dr. Mills?_____
Client's Physician:_____Phone Number: (____)_____
Full Address:_____

**May we contact this physician in order to coordinate care?**___Yes___No_____Initials

## Development

Was pregnancy with this child full-term? Y / N If "No," what was length of pregnancy? _____ weeks

Child's weight at birth: _____

Was this child exposed in utero to any of the following:

| | |
|---|---|
| prescription medications | Y / N |
| illegal drugs | Y / N |
| alcoholic beverages | Y / N |
| cigarette smoke | Y / N |
| serious illness or injury to mother | Y / N |

Did any of the following occur with your child during delivery or within the first few days after birth? (check all that apply)

| | |
|---|---|
| ___ baby injured during delivery | ___ was jaundiced (turned yellow) |
| ___ cardiopulmonary distress at delivery | ___ was cyanotic (turned blue) |
| ___ delivered with cord around neck | ___ had seizures |
| ___ trouble breathing following delivery | ___ received medications |
| ___ needed oxygen | ___ born with congenital defect |
| ___ had an infection | ___ was in the hospital more than 7 days |

Which of the following describes your child's temperament DURING THE FIRST YEAR OF LIFE (check all that apply):

| | |
|---|---|
| ___ difficult to feed | ___ affectionate |
| ___ difficult to get to sleep | ___ sociable |
| ___ colicky | ___ easy to soothe and comfort |
| ___ difficult to put on a schedule | ___ difficult to keep occupied |
| ___ alert | ___ overactive; in constant motion |
| ___ cheerful | ___ extremely stubborn, challenging |

At what age did your child first accomplish the following developmental milestones:

| | |
|---|---|
| sitting without assistance | _____months |
| crawling | _____months |
| walking without assistance | _____months |
| using single words | _____months |
| putting two or more words together | _____months |
| bowel training, daytime and nighttime | _____months |
| bladder training, daytime and nighttime | _____months |

## Physical Health

Has your child had any of the following (check all that apply):

___ tics
___ asthma
___ allergies
___ diabetes
___ arthritis
___ epilepsy, other seizure disorder
___ febrile seizures
___ heart or blood pressure problems
___ fever(s) over 103 degrees
___ broken bones
___ cuts requiring stitches
___ head injury with loss of consciousness
___ lead poisoning
___ surgery
___ lengthy hospitalization
___ speech or language problems
___ chronic ear infections
___ hearing difficulties
___ eye or vision problems
___ fine motor / handwriting problems
___ gross motor difficulties, clumsiness
___ appetite problems (over-eating or under-eating)
___ sleep problems (falling asleep, staying asleep)
___ wetting or soiling problems

Date of child's last physical examination:_____

Use this space to describe other health issues:_____

## Psychological History

| HISTORY OF: | CHILD | SIBLINGS | MOTHER | FATHER | MOTHER'S FAMILY | FATHER'S FAMILY | |
|---|---|---|---|---|---|---|---|
| ADHD | | | | | | | |
| Anxiety Problems | | | | | | | |
| Phobias | | | | | | | |
| Depression | | | | | | | |
| Suicide | | | | | | | |
| Learning Problems | | | | | | | |
| Mental Retardation | | | | | | | |
| Bipolar Disorder | | | | | | | |
| Tics / Tourette's | | | | | | | |
| Alcohol Abuse | | | | | | | |
| Substance Abuse | | | | | | | |
| Physical Abuse | | | | | | | |
| Sexual Abuse | | | | | | | |
| Seizures / Epilepsy | | | | | | | |
| Outpatient Psych. Treatmt | | | | | | | |
| Inpatient Psych. Treatmt | | | | | | | |
| Other Medical Issues | | | | | | | |
| Other Psychiatric Issues | | | | | | | |
| | | | | | | | |

Has this child had previous therapy or counseling? YES / NO
If "Yes," what was the purpose of the therapy? _____

Has this child ever undergone psychological testing of any kind? YES / NO

Has this child ever been prescribed medication for emotional / psychological illness? YES / NO
Please specify:

| Name of Medication | Dosage | From / To |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## School Situation

Client's School:_____Phone Number: (____)_____
Full Address:_____
Grade:_Name of Teacher:_____Name of School Counselor:_____
Teacher E-Mail:_____Counselor E-Mail:_____

Is this child on an Individual Education Plan (IEP) or 504 Plan at school? YES / NO
If "Yes," specify which, and briefly describe accommodations: _____
_____
_____
_____

Has this child ever:

| | |
|---|---|
| Been tested by the school? | *Date of testing*:_____ |
| Failed a subject? | *Which grade*?_____ |
| Repeated a grade? | *Which grade*?_____ |
| Been suspended? | *When*?_____ |
| Been expelled? | *When*?_____ |

What are your child's typical grades in school?_____
What are his / her academic strengths?_____
What are his / her academic weaknesses?_____

## Social History

Does this child have trouble making friends?
_____Never or Almost Never _____Sometimes _____Most of the Time _____Almost Always

Does this child have trouble keeping friends? YES / NO

How old are most of your child's friends?
_____Younger than my child _____Same Age _____Older

How many close friends does this child have?
_____None _____One or Two _____Three to Five _____More than Five

Does your child have friends of whom you do not approve? YES / NO

Please describe any other concerns you have about your child's peer relationships:_____
_____
_____
_____

## Family Situation

Please note which of the following have affected this child's immediate family in the past 12 months:

| | | |
|---|---|---|
| _____pregnancy | _____psychiatric problems | _____legal problems |
| _____new sibling | _____death of relative / friend | _____medical problems |
| _____marriage | _____change in residence | _____financial strain |
| _____marital discord | _____change in work schedule | _____other |
| _____separation/divorce | _____job loss / layoff | |

IF YOUR CHILD HAS SIBLINGS: In general, how does this child get along with brothers / sisters?_____

_____

_____

FOR MOTHER: Please briefly describe your relationship with this child:_____

_____

_____

_____

FOR FATHER: Please briefly describe your relationship with this child:_____

_____

_____

_____

FOR OTHER PRIMARY PARENT(S): Please briefly describe your relationship with this child:_____

_____

_____

_____

_____

Is this child adopted? YES / NO

If "Yes," is the child aware of this? YES / NO

Do you own firearms? YES / NO

Does your child have unsupervised access to the Internet? YES / NO_

Does your child participate in organized sports? YES / NO

Are there any *current*, *past*, or *pending* legal actions involving this child? YES / NO

If yes, please check all that apply:

_____ Child Protective Services _____ Divorce / Custody _____ Truancy

Other (specify):_____

In the space below, please describe any other issues you would like to share regarding this child:

_____ _____

Signature of Client or Parent/Guardian Date

_____ _____

Clinical Psychologist Date