NURTURE CHILD & FAMILY THERAPY CENTER

Child Information Form

This is a detailed questionnaire that will help me greatly in getting to know your child. Please try to answer as fully as possible, although some information may be difficult to remember. We will review everything together at our initial meeting and expand further on any information, as needed.

Date:_____

I. GENERAL INFORMATION

Child's Name:_____ Date of Birth:_____ Age:_____
Name preferred to be called/Nickname: _____
Current Address_____

Parent/Guardian 1 *(Start with person completing the form):*
Name:_____ Age:_____
Relationship to Child (specify biological, adoptive, step, other):_____
Occupation: _____ Highest level of education: _____
Phone: Home: _____ Cell: _____ Work: _____
E-mail address: _____
Preferred method to be contacted (check): ____home phone, ____cell phone, ____e-mail
May I leave a message on phone? ___Yes ___No

Parent/Guardian 2:
Name:_____ Age:_____
Relationship to Child (specify biological, adoptive, step, other): _____
Occupation: _____ Highest level of education: _____
Phone: Home: _____ Cell: _____ Work: _____
E-mail address: _____
Address (if different than above):_____
Preferred method to be contacted (check): ____home phone, ____cell phone, ____e-mail
May I leave a message on phone? ___Yes ___No

Parents' current marital status: ___Married ___Never Married ___Separated
___Divorced ___Partnered ___Widowed
If divorced, who is the managing conservator? _____
**Please attach a copy of the most current legal custodial order issued by court, consisting of the cover page, page specifying conservator(s), and signature page.*

Household composition (Please include step-parents, partners, roommates, etc.)

Name Relationship to child Age

_____

_____

_____

_____

_____

If any brothers or sisters living outside the home, list their names and ages**:**

_____

If parents are separated/divorced, how old was child when this separation occurred?_____

What arrangements, if any, are there for visitation or shared custody?_____

_____

Second Household composition (if applicable)

Name Relationship to child Age

_____

_____

_____

_____

_____

In cases of adoption:

How old was your child when s/he arrived in your home?_____

What information were you given about the biological parents and your child's early history?

_____

II. MEDICAL & DEVELOPMENTAL HISTORY

Pregnancy & Birth History:

Length of Pregnancy:_____ weeks

List medications taken during pregnancy and the reason used_____

_____

Check any of the following that was present during your pregnancy with this child:

___High blood pressure ___Excessive bleeding ___Physical injury/Accidents

___Infections ___Convulsions ___Diabetes ___Anemia ___Blackouts

___Use of nonprescription drugs ___Consumption of alcohol ___Cigarette smoking

___Emotional stress ___Other medical conditions (specify: _____)

Type of delivery: ___Vaginal, ___Induced labor, ___C-section, ___Other (specify:_____)

Complications during labor or delivery? _____

Birth weight of child:_____

Child's condition at birth: ___Healthy ___Lack of oxygen ___Breathing problem
___Birth injury/defect ___Jaundice ___Newborn ICU (# of days_____)
___Other problems (specify:_____)

Developmental History

Describe your child as an infant/toddler:_____

During your child's first few years of life, was any of the following present to a significant degree?

___Problems with nursing/feeding ___Severe colic or excessive crying ___Irritable
___Overactive ___Easily overstimulated ___Withdrawn ___Did not like to be held
___Difficult to soothe ___Did not turn towards caregivers ___Diminished sleep

Did your child have problems with:

___Sitting up ___Walking ___Talking ___Toileting ___Bedwetting
___Writing letters or using scissors ___Reading or letter identification
___Physical coordination (running, jumping, climbing)
___Responding to discipline or behavior management
___Anger/temper tantrums ___Fears ___Sexual play

Any additional comments/concerns regarding your child's early development?_____
_____

Medical History:

Name of pediatrician: _____ Date of last physical: _____
Address: _____
Phone:_____ Fax: _____

Describe the state of your child's current health: ___Excellent ___Good ___Fair ___Poor

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

Please describe and give details, dates and/or age of onset; use the back of the page, if needed:

___Serious illnesses _____
___Head injuries/concussions _____
___Seizures/convulsions _____
___Surgery/hospitalization _____
___Frequent ear infections _____
___Allergies and/or asthma _____
___Vision problems _____
___Hearing problems _____
___Chewing/swallowing difficulties _____
___Bedwetting _____
___Headaches _____
___Other health problems _____

Has your child ever received a mental health-related diagnosis or been identified as having a disability? ___Yes ___No
If so, by whom, what age, and what diagnosis/disability?_____
_____
Has your child ever participated in therapy services (e.g., psychological counseling, speech, occupational, physical, vision therapy, etc.): ___Yes ___No
If so, please specify the service, date/duration of service, and provider (agency/professional):
_____
_____
**Please provide recent evaluations, if applicable.*

Please list all medication child is taking; both prescribed and over the counter:
Medication Purpose Dose Taken regularly?
_____
_____
Who is the doctor that prescribed these medications?_____

Family History:
Please check if anyone in the child's biological family has ever had any of the following problems:

	Relationship to Child:
___ADHD (i.e., attention problems/hyperactivity)	_____
___Behavior problems in youth	_____
___Learning disorder (e.g., reading, math, writing, spelling)	_____
___Speech and language delays/problems	_____
___Intellectual disability	_____
___Autism spectrum disorder	_____
___Tics/Tourette's syndrome	_____
___School failure (failing grades, dropout, etc.)	_____
___Emotional problems (e.g., depression, anxiety)	_____
___Bipolar disorder	_____
___Obsessive-compulsive disorder	_____
___Psychotic disorders (e.g., schizophrenia)	_____
___Trauma- and stressor-related disorders	_____
___Alcohol/drug use	_____
___Problem with the law	_____
___Suicide (or attempts)	_____
___Physical/sexual abuse	_____
___Psychiatric hospitalizations	_____
___Seizures	_____
___Other_____	_____

III. SCHOOL/EDUCATIONAL HISTORY

Please list all schools (including locations) that your child has attended in the past:

1. _____ From grade____ to grade____
2. _____ From grade____ to grade____
3. _____ From grade____ to grade____
4. _____ From grade____ to grade____

Has your child received any special help in these schools (e.g., tutoring, special education, therapy)? Please specify the service, date/duration of service, and provider.

_____

_____

Current educational placement/functioning:

School currently attending:_____ Grade:_____

Teacher(s): _____

Is your child currently receiving any services/accommodations? Does child have an IEP or 504 plan?_____

_____

Has your child ever repeated or skipped a grade? ___Yes ___No If yes, which grade(s)?_____

Has your child ever been suspended or expelled? _____

How does your child feel about school?_____

How motivated do you feel your child is to learn?_____

How much struggle is homework? ___Not a struggle ___Sometimes ___Often a struggle

What are your child's academic strengths?_____

_____

What are your child's academic weaknesses?_____

_____

Grades: ___Above average ___Average ___Below Average

Behavioral problems at school:_____

_____

Relationships with teachers: ___Excellent ___Usually gets along ___Has problems:_____

_____

Relationships with peers at school: ___Excellent ___Usually gets along ___Has problems:

_____

IV. SIGNIFICANT LIFE EVENTS ***(****Please check all that apply):*

___Separation from parent(s) (how long and when)_____

___Death of a loved one ___Parental separation/divorce ___Custody dispute

___Parental conflict ___Move/School change ___Financial stress

___Remarriage/new partner ___Birth of a new sibling ___Health problems

___Legal problems ___Drug/alcohol abuse

___Trauma (violence, natural disaster, car accident, etc.) ___Other (specify)_____

Please list all locations (city, state, country) that your child has lived in:
1. _____Moved at Age____ Grade____
2. _____Moved at Age____ Grade____
3. _____Moved at Age____ Grade____
4. _____Moved at Age____ Grade____

What other stressors have impacted or currently impacting your child? _____
_____

V. BEHAVIORAL AND EMOTIONAL HISTORY

For each item that applies, write in your child's approximate age at the time it occurred.
School Concerns:
___Academic problems ___Discipline problems ___Severely teased ___Unpopular
___Anxiety issues ___School refusal ___Other (explain)_____
Emotional Concerns:
___Refusal to speak in certain situations ___Appetite changes ___Sleep changes
___Extreme sadness ___Tics or nervous habits ___Obsessive thoughts ___Phobias
___Suicidal thoughts ___Hearing voices ___Extreme anxiety ___Other _____
Behavior Concerns:
___Aggressive behavior (explain)_____
___Alcohol/drug use ___Attention problems ___Overly active ____Frequent arguments
___Impulsive ___Loner ___Lack of respect for authority ___Aggression toward animals
___Victim of bullying ___Perpetrator of bullying ___Fighting
___Tantrums (explain)_____
Other: _____
_____
_____

VI. SOCIAL RELATIONSHIPS & ACTIVITIES/INTERESTS

Does your child have a friend or friends outside the family? ___Yes ___No
What are his/her best friends' names and ages?_____
_____
Is your child invited to birthday parties, play dates, etc.? ___Yes ___No
How well does your child get along with peers?_____
_____
How is child's relationship with parent(s)? _____
_____
What does family do together to have fun (activities, play, etc., excluding electronics)? How much time in a day/in a week?:_____
_____
_____

How does child respond to limits? _____

_____

How do parents respond to undesirable behaviors? _____

_____

Extracurricular activities:_____

_____

Leisure time activities/interests:_____

_____

Strengths or Abilities:

___Academics/grades ___Sports ___Creative (art or music, etc)
___Social relationships ___Care for others ___Sense of humor
___Group involvement (clubs, organizations)
Other: _____

_____

VII. PRESENTING PROBLEM

Current Concerns about Your Child:

___Behavior at home/school ___Mood ___Eating ___Sleeping
___Academic performance/grades ___ Peer relationships ___Anger/Irritability
___ Difficulty paying attention ___Sensory sensitivities ___Frequent worries/shyness
___Health ___Drugs/alcohol ___Sexual behavior ___Suicidal thoughts

Briefly describe your child's current difficulties and the reason you are seeking services?

_____

_____

_____

_____

_____

_____

_____

_____

How long has this been a problem? _____

_____

What seems to help? _____

_____

What seems to make problem worse? _____

_____

What have you tried before to help with these difficulties? _____

_____

Other struggles/concerns: _____

_____

_____

Other comments: _____

_____

What are your most important goals/expectations for therapy?

1. _____
2. _____
3. _____

How did you hear about me and my services?

_____

_____