Kasandra Wheeler, PLLC
LICENSED PROFESSIONAL COUNSELING

Child Information Form

Today's date: _____/_____/_____

A. Identification

Child's full name: _____ Date of birth: ____/____/____

Child's legal guardian: _____ Person(s) completing this form: _____

Racial/ethnic identities: _____

Religious/spiritual traditions or identity: _____

B. Family information

Mother/guardian: _____

Best phone number: _____ Other phone number: _____

Address: _____

Email: _____ Occupation: _____

Employer: _____

Father/guardian: _____

Best phone number: _____ Other phone number: _____

Address: _____

Email: _____ Occupation: _____

Employer: _____

Parents are currently: ❑ Married ❑ Divorced ❑ Separated ❑ Remarried to others ❑ Never married
❑ Other: _____

Patient lives with: ❑ Mother ❑ Father ❑ Relative ❑ Guardian ❑ Other: _____

Who has legal custody* of this child? ❑ Mother ❑ Father ❑ Both/either/shared ❑ Relative
❑ Guardian ❑ Other: _____

Siblings: _____

C. 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: _____

D. Referral

How did you hear about us? _____

E. Current problems or difficulties

Please describe the main difficulties that led to your bringing this child to see me: _____

_____

When did these problems start? _____

F. Education

What year of school is your child currently in _____.

What is the name of your child's current school _____

G. Health and medical care

1. How is your child's general level of health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor
2. Pediatrician/PCP/Clinic/doctor's name: _____

   Phone: _____
3. List all childhood illnesses, hospitalizations, medications, allergies, important injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age, or from-and-to ages	Treated by whom? Mark the primary care provider (PCP) with a star.	Effects/outcome

6. Has your child ever received inpatient or outpatient psychological, psychiatric, drug or alcohol treatment, medications or counseling services before? ❑ No ❑ Yes. If yes, please indicate:

For what (diagnoses)?	From (date)	To (date)	Name of doctor, provider, or agency and location	What kind of treatment?	With what results?

For what (diagnoses)?	From (date)	To (date)	Name of doctor, provider, or agency and location	What kind of treatment?	With what results?

7. Has any other family member been hospitalized for a psychiatric, emotional, or substance use disorder?
   ❑ No ❑ Yes. If yes, please indicate:

Name of family member	For what (diagnoses)?	What kind of treatment?	From (date)	To (date)	With what results?

8. Describe any substance abuse or mental illness in family members (who, relationship, disorder, currently active?): ___

9. Has the child had any residential placements, institutional placements, or foster care? ❑ No ❑ Yes. If yes, please indicate:

Age entered	Age left	Program's name	Reason for placement	Problems there

10. Other important family issues (losses, adoption, stepparents, other relatives): _____

H. Abuse history

Note: If I suspect that there is or has been abuse, I have to report that. Please be aware of this as you answer the questions below, or leave them blank.

❑ This child was not abused in any way. ❑ This child may have been abused.

❑ This child was abused. For the kind of abuse, use these letters: P = Physical, such as beatings; S = Sexual, such as touching/molesting, fondling, or intercourse; N = Neglect, such as failure to feed, shelter, or protect; E = Emotional, such as humiliation, etc.

Child's age	Kind of abuse	By whom? Intimate partner? Relative? Sibling? Other (specify)?	Effects on the child?	Whom did the child tell?	What happened then?

I. Legal history

1. Are you or your child presently being sued, suing anyone, or thinking of suing anyone? ❑ No ❑ Yes. If yes, please explain: _____

2. Is your reason for bringing the child to see me related to an accident or injury? ❑ No ❑ Yes. If yes, please explain: _____

3. Are you or your child required by a court, the police, or a probation/parole officer to have this appointment?
   ❑ No ❑ Yes. If yes, please explain: _____

J. Special skills or talents of the child

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

K. Friends of the child

How many? ____ Their gender: ❑ Only same ❑ Both ❑ Only other

Their ages: ❑ About the same as my child ❑ Mostly older ❑ Mostly younger

Activities with friends: _____

Influence of friends on child: ❑ Positive ❑ Negative. Specifics: _____

L. Other

Is there anything else that is important for me as your child's therapist to know about, and that you have not written about on any of these forms? ❑ Yes, and I have written about it on the back of this page or another sheet of paper.

Please do not write below this line.

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.