Care Centered Counseling, LLC

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CLIENT INFORMATION FORM

This Form is Confidential

Today's date:		
Your child's name:		
Last	First	Middle Initial
Parent or Legal Guardian's Name: _		
<u> </u>	Last Firs	t Middle Initial
Child's date of birth:	Gender:	
Parent or Legal Guardian's Social Se	ecurity #:	
Home street address:		
City:	State:	Zip:
Parent or Legal Guardian's Name of	f Employer:	
Address of Employer:		
City:	State:	Zip:
Home Phone:	Work Phone:	
Cell Phone:	Email:	
Calls will be discreet, but please indi	•	
Referred by:		
- May I have your permission to the Yes No	hank this person for the referral?	
- If referred by another clinician, Yes No		
Person(s) to notify in case of any em	nergency:	
We will only contact this person if v signature to indicate that we may do so	we believe it is a life or death emo	ergency. Please provide your
Please briefly describe your child's p	oresenting concern(s):	
What are your/your child's goals for	thomany	

MEDICAL HISTORY:								
Please explain any significant medical problems, symptoms, or illnesses your child has had:								
Current Medications (if yo Name of Medication			k of this page): Name of Prescribing Doctor					
•	,	•						
Previous psychiatric hospital	izations (Approxima	te dates and reasons):						
list approximate dates and re	easons):		ental health professional? (If yes, please					
Sexual & Gender Identity:	Heterosexual Transgender	_LesbianGay _AsexualIn (Bisexual QuestionOther:					
Racial/Ethnic Identity:African/African-AmericanAmerican Indian/Alaska IAsian/Asian-American/ABi-Racial/Multi-Racial	Native		rn/Middle Eastern-American					
FAMILY:								
How would you describe you	ur child's relationship	o with his or her moth	er?					
,	1		.?					

Please describe your child's relationship with his or her grandparents:
Were there any other primary care givers who have had a significant relationship with your child? If so, please describe how these people may have impacted your child's life:
How many sisters does your child have? Ages?
How many brothers does your child have? Ages?
How would you describe your child's relationships with his or her siblings?
SOCIAL SUPPORT, SELF-CARE, & EDUCATION: POOR EXCELLENT
Child's current level of satisfaction with friends and social support: 1 2 3 4 5 6 7
How would you describe your child's relationships with his/her peers?
Please briefly describe any history of abuse, neglect and/or trauma:
Please briefly describe your child's self-care and coping skills:
What are your child's diet, weight, and exercise/activity patterns?
Please briefly describe your child's school performance and experience:
What are your child's hobbies, talents, and strengths?

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD & CIRCLE THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety				Tantrums			Nausea		
Depression				Parents Divorced			Stomach Aches		
Mood Changes				Seizures			Fainting		
Anger or Temper			П	Cries Easily			Dizziness		
Panic				Problems with Friend(s)			Diarrhea		
Fears				Problems in School			Shortness of Breath		
Irritability			\parallel	Fear of Strangers			Chest Pain		
Concentration				Fighting with Siblings			Lump in the Throat		
Headaches				Issues Re: Divorce			Sweating		
Loss of Memory				Sexually Acting Out			Heart Problems		
Excessive Worry				History of Child Abuse			Muscle Tension		
Wetting the Bed			\parallel	History of Sexual Abuse			Bruises Easily		
Trusting Others				Domestic Violence			Allergies		
Communicating with Others				Thoughts of Hurting Someone Else			Often Makes Careless Mistakes		
Separation Anxiety				Hurting Self			Fidgets Frequently		
Alcohol/Drugs				Thoughts of Suicide			Impulsive		
Drinks Caffeine				Sleeping Too Much			Waiting His/Her Turn		
Frequent Vomiting				Sleeping Too Little			Completing Tasks		
Eating Problems				Getting to Sleep			Paying Attention		
Severe Weight Gain			\prod	Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss				Nightmares			Hyperactivity		
Head Injury				Sleeping Alone			Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems	Physical Abuse		Depression	
Legal Trouble	Sexual Abuse		Anxiety	
Domestic Violence	Hyperactivity		Psychiatric Hospitalization	
Suicide	Learning Disabilities		"Nervous Breakdown"	