

CHILD AND FAMILY INFORMATION FORM

Date \_\_\_\_\_

CHILD'S INFORMATION

Child's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Child's SSN: \_\_\_\_\_ Child's DOB: \_\_\_\_\_ Age: \_\_\_\_\_

The Child Resides with: Mother: \_\_\_\_\_ Father: \_\_\_\_\_ Both: \_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ has legal custody of this child.

Child's Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Parent(s) Work Phone: \_\_\_\_\_ Wk Hrs: \_\_\_\_\_

Grade in School: \_\_\_\_\_ Teacher's Name: \_\_\_\_\_ School Name: \_\_\_\_\_

Child's Strengths:

\_\_\_\_\_  
\_\_\_\_\_

Child's Hobbies/Interests:

\_\_\_\_\_  
\_\_\_\_\_

**School Information:**

Grade: \_\_\_\_\_ Teacher's Name: \_\_\_\_\_ School Name: \_\_\_\_\_

What kind of grades does your child usually get? A's B's C's D's  
F's

Does your child have an Individual Education Plan (IEP)? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain as fully as possible: \_\_\_\_\_

Has your child been suspended or expelled from school within the last 2 years: Yes \_\_\_ No \_\_\_

If yes, explain. \_\_\_\_\_

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What school activities does your child participate in? \_\_\_\_\_

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What community activities does your child participate in? \_\_\_\_\_

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Does your child attend church regularly? Yes \_\_\_\_\_ No \_\_\_\_\_ which one:  
\_\_\_\_\_

Has your child had any contact with the Juvenile Court System within the last 2 years?  
Yes \_\_\_ No \_\_\_\_\_

If yes, please explain. \_\_\_\_\_

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FAMILY INFORMATION

Parents Name(s): \_\_\_\_\_ / \_\_\_\_\_

Step Parent Name(s): \_\_\_\_\_ / \_\_\_\_\_

List the name, age, sex and relationship of all the people that reside in the home with the child.

<u>RELATIONSHIP</u>	<u>NAME</u>	<u>AGE</u>	<u>SEX</u>
1.	_____	_____	_____
	_____		
2.	_____	_____	_____
	_____		
3.	_____	_____	_____
	_____		
4.	_____	_____	_____

_____		
5. _____	_____	_____
_____		
6. _____	_____	_____
_____		

Have any other family members or adults been the primary caretakers for your child for longer than a one-month period since birth?

<u>LENGTH OF STAY</u>	<u>WHO</u>	<u>RELATIONSHIP TO THE CHILD</u>	<u>AGE AT PLACEMENT</u>
1. _____	_____	_____	_____
_____			
2. _____	_____	_____	_____
_____			
3. _____	_____	_____	_____
_____			
4. _____	_____	_____	_____
_____			

Has anyone in your child's immediate family, close relatives or friends died? Yes \_\_\_ No \_\_\_

If so, who? \_\_\_\_\_ When?  
\_\_\_\_\_

Has your child ever seen a psychiatrist? Yes \_\_\_ No \_\_\_ If yes, when? \_\_\_\_\_

Name of Psychiatrist(s): \_\_\_\_\_

Medication(s) Prescribed: \_\_\_\_\_

Reason for medication(s): \_\_\_\_\_

Has your child ever seen a counselor/therapist? Yes\_\_\_\_\_No\_\_\_\_\_

If yes, when?:\_\_\_\_\_

Name of the Counselor/Therapist:\_\_\_\_\_

Reason for the Counseling: \_\_\_\_\_

Was it helpful? \_\_\_\_\_

Please describe your reason(s) for seeking treatment for your child at this time:

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What are you hoping will change as a result of your child and family participating in counseling:

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**Please indicate any parent/family concerns:**

\_\_\_ Child has witnessed Domestic Violence  
community

\_\_\_ Victim of Abuse (physical /sexual)

\_\_\_ Divorce/separation concerns

\_\_\_ Family Relationship Issues  
problems

\_\_\_ Bedwetting  
assault

\_\_\_ Aggressive behavior

\_\_\_ Argues with Adults  
comply with

\_\_\_ Bullies, Threatens, or intimidates others

\_\_\_ Stealing

\_\_\_ School Problems  
attention to tasks

\_\_\_ Has difficulty following through on tasks

\_\_\_ Gets very upset when separated from parents

\_\_\_ Witnessed violence within the

\_\_\_ Grief/loss issues

\_\_\_ Family Communication

\_\_\_ Victim of personal

\_\_\_ Loses Temper

\_\_\_ Frequently refuses to

directives

\_\_\_ Lying

\_\_\_ Has Difficulty paying

- Peer/sibling relationship problems
- Tries to avoid going to school in order to stay home with parent
- Has difficulty controlling worries

- |   |   |
|---|---|
| <input type="checkbox"/> Depression   | <input type="checkbox"/> Difficulty sleeping                |
| <input type="checkbox"/> Difficulty identifying & expressing feelings in healthy ways | <input type="checkbox"/> Nightmares                         |
| <input type="checkbox"/> Unhappy most of the time                                     | <input type="checkbox"/> Frequent crying spells             |
| <input type="checkbox"/> Shows little interest in activities                          | <input type="checkbox"/> Has little confidence or very self |

conscious

- Suicidal Thoughts

- |   |   |
|---|---|
| <input type="checkbox"/> Unusual & Persistent fears   | <input type="checkbox"/> Shows excessive fear to specific objects or situations |
| <input type="checkbox"/> Feels compelled to perform unusual habits (hand washing, checking locks) |   |

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|---|--|
| <input type="checkbox"/> Strange ideas or beliefs that are not real | <input type="checkbox"/> Strange & Illogical thoughts or ideas |
| <input type="checkbox"/> Hearing voices                             |  |

- |   |  |
|---|--|
| <input type="checkbox"/> Has a peculiar way of relating to others       | <input type="checkbox"/> Has a significant problem with language |
| <input type="checkbox"/> Gets very upset over small changes in routines |  |

- Frequent complaints about physical problems

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|--|--|
| <input type="checkbox"/> Is experimenting with alcohol | <input type="checkbox"/> Is experimenting with drugs |
| <input type="checkbox"/> Has a substance abuse problem |  |

- Difficulties associated with eating

**Please indicate any stressors that are impacting the child and/or caregivers:**

- Drug/Alcohol (family member other than client)
- Mental health issue of family member
- Parents disagree over the care & discipline of the child/children

Adjustment issues related to:

- |   |   |
|---|---|
| <input type="checkbox"/> Marital/relationship issues    | <input type="checkbox"/> Stress management problems |
| <input type="checkbox"/> Primary caregiver is exhausted | <input type="checkbox"/> Language barrier problems  |

\_\_\_\_\_ other \_\_\_\_\_

**Please complete the following:**

1. Yelling and threatening your child will change their behavior  
(a) Agree (b) disagree (c) undecided
2. Humiliating or embarrassing a child is an effective method to eliminate misbehavior.  
(a) Agree (b) disagree (c) undecided
3. Children who have behavioral problems do not fear their parents  
(a) Agree (b) disagree (c) undecided
4. Time outs are not an effective discipline technique  
(a) agree (b) disagree (c) undecided
5. Positive reinforcement is less effective in gaining children's compliance  
(a) agree (b) disagree (c) undecided

Please provide any additional information, which you feel may be useful for the counselor to know.

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