



Child and Family Information Form

Child's legal name: _____ Child's preferred name: _____

Today's Date: _____ Date of Birth: _____

Gender: M / F / Other: _____ Age: _____

Racial/Ethnic identification: _____

Person completing this form: _____

Relationship to the child: _____

Service Requested (check all that apply): Evaluation: ____ Therapy: ____ Medication: ____

Person who referred you to this clinic: _____

Relationship to the child: _____

Language(s) spoken by child/caregivers: _____

Registration Information

Child's Current Address: _____

City: _____ State: _____ Zip code: _____

Child lives with (check all that apply): Mother(s): ____ Father(s): ____ Adoptive parent(s): ____

Other (please explain): _____

If the child is not living with both parents, please explain: _____

If the child has a parent not living with the child, are there visitations? Yes: ____ No: ____

Insurance Information

Insurance carrier: _____

Insurance Member ID#: _____ Insurance Group #: _____

Parent/Caregiver's Information

Caregiver 1's name: _____

Telephone number(s): H: _____ W: _____ C: _____

Address (if different from child's): _____

City: _____ State: _____ Zip code: _____

Parent's preferred email: _____

(Label)

Caregiver 2's name: _____

Telephone number(s): H: _____ W: _____ C: _____

Address (if different from child's): _____

City: _____ State: _____ Zip code: _____

Other parent/caregiver name(s): _____

Telephone number(s): H: _____ W: _____ C: _____

Address (if different from child's): _____

City: _____ State: _____ Zip code: _____

Foster Parent or Other Current Primary Caregiver, if applicable

Name: _____

Telephone number(s): _____ Relationship: _____

Custody

Who has legal custody of the child: _____

Telephone number(s): H: _____ W: _____ C: _____

Address (if different from child's): _____

City: _____ State: _____ Zip code: _____

Back-up Emergency Contact

Name: _____

Telephone number(s): _____ Relationship: _____

School Information

School name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Telephone number: _____ Teacher's name: _____ Child's Grade: _____

Family and Home Information

All people currently living with the child:

Name	Birth Date	Age	Sex	Relationship
_____	_____	___	M / F	_____
_____	_____	___	M / F	_____
_____	_____	___	M / F	_____
_____	_____	___	M / F	_____
_____	_____	___	M / F	_____

(Label)

Has your child had any long separations from any parents or siblings? Yes: _____ No: _____

If "yes," please explain: _____

Has your child or family experienced any traumatic or very scary events? Yes: _____ No: _____

If "yes," please explain: _____

Has your family ever experienced domestic violence? Yes: _____ No: _____

To your knowledge, has your child ever been physically abused? Yes: _____ No: _____

To your knowledge, has your child ever been sexually abused? Yes: _____ No: _____

Has your family ever been involved with Child Protective Services Yes: _____ No: _____

If "yes," please explain: _____

Has there been a time in the last 12 months when your family did not have enough money to buy food or food to eat? Yes: _____ No: _____

Child's Developmental History

Were there any problems during pregnancy or delivery? Yes: _____ No: _____

If "yes," please explain: _____

Was the baby exposed to cigarettes, drugs or alcohol during the pregnancy? Yes: _____ No: _____

If "yes," please explain: _____

At what age did your child: Walk: _____ Say 1st words: _____ Fully toilet trained: _____

Were there any difficulties or delays? Yes: _____ No: _____

If "yes," please explain: _____

Are there any problems now with bedwetting/accidents? (check all that apply)

Daytime accidents: _____ Nighttime accidents: _____ No accidents: _____

Was your child adaptable, easy to soothe, easy to please and/or easy to discipline? Yes: _____ No: _____

Has your child been referred for/or participated in any special programs? Yes: _____ No: _____

Child's Medical History

Clinic where your child receives primary care: _____

Primary care provider's name: _____

Does your child have allergies to food or medication: Yes: _____ No: _____

If "yes," to what does your child have allergies? _____

Please list any current or past health problems, hospitalizations or surgeries your child has had: _____

Please circle if your child has a history of the following conditions: head injury, loss of consciousness, seizure

Please circle if your child CURRENTLY has a problem with one of the following: chronic pain, eating, sleeping

Please list any medications your child is currently taking: _____

Please list any previous mental health services (therapy, evaluation or medication) your child has received:

Family Mental Health History

Illness or Problem	Biological Mother	Biological Father	Adoptive Parent	Adoptive Parent	Biological Sister or Brother	Other Relative
Depression						
Bipolar Disorder						
Suicide Attempt						
Anxiety						
Schizophrenia						
Autism Spectrum Disorder						
Learning Problem						
Behavior Problem						
Attention Problem						
Alcohol/drug Problem						
Other						

Please describe your concerns about your child (emotions, behavior, learning, getting along with people, etc.), using space on the following page as needed: _____
