

# Dipoto Counseling Group

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## CLIENT INFORMATION FORM

Child's Full Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_  
Address: \_\_\_\_\_  
(Street) (City) (State) (Zip code)  
School: \_\_\_\_\_ Grade: \_\_\_\_\_  
(Name) (City)  
Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_  
Employer: \_\_\_\_\_ Employer: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Home phone: \_\_\_\_\_  
Work phone: \_\_\_\_\_ Work phone: \_\_\_\_\_  
Cell phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
Parent's marital status: \_\_\_\_\_  
Step-mother: \_\_\_\_\_ Step-father: \_\_\_\_\_  
Current custody arrangement (if applicable): \_\_\_\_\_

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**Are you the child's legal guardian?** Yes  No

*If no, please list the following information for the legal guardian or other parent/legal guardian:*

Name: \_\_\_\_\_ Relation to Child: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip code)

Phone: \_\_\_\_\_ Alternate phone: \_\_\_\_\_

**To (re)schedule or confirm appointments, where may I call?**

**Home:** Yes  No  **Work:** Yes  No  **Cell:** Yes  No

May I leave a message on the answering machine? Yes  No

May I leave a message with someone at this number? Yes  No

Please list any restrictions: \_\_\_\_\_

**Whom may I contact in case of an emergency?**

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate phone: \_\_\_\_\_

**Family Information:**

Please list siblings (full/half/step) siblings in order of age:

<i>Name</i>	<i>Relationship</i>	<i>Age</i>	<i>History of illness (physical/mental)</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other people living in the home: \_\_\_\_\_

Non-residential adults involved with your child on a regular basis (e.g., babysitter): \_\_\_\_\_

**Developmental/Medical Information:**

At what age did your child achieve these milestones?:

Walked _____	Said first word _____
Toilet trained _____	Spoke first sentence _____

Any speech, hearing, or learning difficulties? Yes  No

Has your child ever received services from a speech pathologist? Yes  No

Has your child ever been evaluated for a special education or Section 504 plan? Yes  No

If yes, does your child have an IEP? Yes  No  Date of most recent review? \_\_\_\_\_

Describe any major illnesses, injuries, or surgeries?

<i>Illness</i>	<i>Hospitalized (yes/no)</i>	<i>Date</i>	<i>Lasting Effects?</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has your child ever had a concussion or serious head trauma? Yes  No

Has your child ever had a seizure? Yes  No

Current medications or special diet? \_\_\_\_\_

What allergies does the child have? \_\_\_\_\_

What other health problems, if any, does the child have? \_\_\_\_\_

\_\_\_\_\_

List any major medical or emotional difficulties in the family? Alcohol or drug problems?

\_\_\_\_\_

**Please complete the following:**

In the space below, please briefly describe the reason(s) for seeking services for your child:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*When did this problem begin?:* \_\_\_\_\_

**Has your child ever had previous counseling or psychotherapy?** Yes  No

If "yes," by whom and when? \_\_\_\_\_

Reason for treatment? \_\_\_\_\_

**Is your child currently taking any psychotropic medication** (e.g. ADHD medication, antidepressants, anti-anxiety, etc.)? Yes  No  *If yes, list medication(s) and current dosage(s):* \_\_\_\_\_

\_\_\_\_\_

**Has your child ever been psychiatrically hospitalized?** Yes  No  *If so, when and where?*

\_\_\_\_\_

**Has your child ever made a suicide attempt/gesture?** Yes  No  *If so, please explain:*

Please use the scale below to indicate your child's current level of distress with the following items:

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	No	Some	Moderate	Urgent
	Concern			
Academic problems	0	1	2	3
Aggressive behavior	0	1	2	3
Anxiety/fears/worries	0	1	2	3
Attention/concentration difficulties	0	1	2	3
Bedwetting	0	1	2	3
Behavior problems	0	1	2	3
Change in family constellation (e.g. divorce or remarriage)	0	1	2	3
Depression	0	1	2	3
Eating problems	0	1	2	3
Feelings over a recent loss/death	0	1	2	3
Losing contact with reality	0	1	2	3
Relationship with family	0	1	2	3
Relationship with peers	0	1	2	3
Problems with alcohol/drugs	0	1	2	3
Sexual behaviors	0	1	2	3
Sleep problems	0	1	2	3
Suicidal feelings/behaviors	0	1	2	3
Trauma/Physical or sexual abuse	0	1	2	3

Please list hobbies, sports, recreational, TV, and toy preferences; any special skills or talents:

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