Dipoto Counseling Group

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CLIENT INFORMATION FORM

Child's Full Name:_____ Today's Date: _____

Date of Birth: _____ Age: _____ Gender: _____ Social Security#: _____

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): _____

_____

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:

Name	*Relationship*	*Age*	*History of illness (physical/mental)*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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?

Illness	Hospitalized *(yes/no)*	Date	Lasting Effects?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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:*

_____

We like to thank our referral sources please let us know who referred you to our practice:

_____

Address: _____ Phone: _____

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

	No Concern	Some	Moderate	Urgent
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:

_____

_____