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CHILD DATA FORM

Please answer all information as completely as possible. Feel free to ask for assistance if needed.

Today's Date: _____

Name of Person filling out this form: _____ Relationship to Child: _____

Child's Name: _____

Last First M.I.

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Gender: M_____ F_____

Child's Address: _____

Street Apt. # City State Zip Code

School: _____ Address: _____

Grade Level (now):_____ School Counselor: _____

School Counselor Phone Number: _____

Child's Home Room Teacher: _____ Phone: _____

Is your child currently on probation? No____ Yes____ Retained? No____ Yes ____

Is your child receiving special educational or other services? No____ Yes ____

Explain: _____

Is your child currently receiving counseling? No____ Yes ____

Mental Health Professional / Agency: _____

Name Phone Number

MOTHER'S INFORMATION

Mother's Name: _____

Last First M.I.

Home Phone: _____ Work Phone: _____ Cell: _____

Address (if different from child's):_____

Street Apt. # City State Zip

Marital Status (indicate all that apply and duration each, ex. 1970-1985):

Never Married_____ Married_____ _Remarried _____

Divorced_____ Separated_____ Widowed _____ Number of Marriages _____

History of learning, emotional, or behavioral problems: Yes _____ No _____ (if yes, explain) _____

_____

History of alcohol/drug/substance abuse: Yes _____ No_____ (if yes, explain) _____

History of family violence: Yes_____ No_____ (if yes, explain) _____

_____

History of criminal activity: Yes_____ No_____ (if yes, explain) _____

_____

FATHER'S INFORMATION

Father's Name: _____

Last First M.I.

Home Phone: _____ Work Phone: _____ Cell: _____

Address (if different from child's):_____

Street Apt. # City State Zip

Marital Status (indicate all that apply and duration each, ex. 1970-1985):

Never Married_____ Married_____ _Remarried _____

Divorced_____ Separated_____ Widowed _____ Number of Marriages _____

History of learning, emotional, or behavioral problems: Yes _____ No _____ (if yes, explain) _____

_____

History of alcohol/drug/substance abuse: Yes _____ No_____ (if yes, explain) _____

History of family violence: Yes_____ No_____ (if yes, explain) _____

_____

History of criminal activity: Yes_____ No_____ (if yes, explain) _____

_____

CHILD'S HEALTH

Child's Physician: _____ Doctor's Phone number: _____

List any present medical problems or current medications: _____

_____

Has child had any previous counseling or psychiatric care? (Please circle) Yes No

If yes, please indicate when and with whom: _____

What did you find most valuable from that experience? _____

Family of Origin

Name	Age	Gender	Relationship to you
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

Please list several attributes you enjoy about your child and make them unique. (talents, personality, strengths, and characteristics)_____

_____

CHILD'S HISTORY AND EXPERIENCES

Please check all that your child has experienced. * Any that is of major concern to you currently.

	Emotional Concerns:		**Suicidal thoughts**		**Suicide Attempts**
	Emotional problems		**Weight Loss**		**Weight gain**
	Appetite change		**Heard voices when no one around**		**Loss of energy or fatigue**
	Mood swings		**Anger**		**Feeling depressed**
	Trouble sleeping		**Crying Spells**		**Social isolation**
	Poor grooming		**Insomnia**		**Sleeping too much**
	Lack of motivation		**Feeling "on top of the world"**		**Lack of enjoyment**
	Self-harm		**Difficulty concentrating**		**Feelings of hopelessness**
	Loneliness		**Risky behavior**		**Decreased interest in hobbies**
	Aggressive behavior				
	Anxiety Symptoms:		**Obsessive worrying**		**Irritable**
	Keyed up, on edge		**Physical symptoms**		**Phobias**
	Anxiety attacks		**Feelings of panic**		**Irrational thoughts**
	Inability to control thoughts		**Racing thoughts**		**Unable to relax**
	Nervous habits (nail biting)		**Social Anxiety**		**Feeling inferior**
	Nightmares		**Nervous tics**		
	Health & Misc. Problems:		**Headache (kind)**		**Nervous Stomach**
	Diarrhea		**Constipation**		**Bedwetting**
	Bone/Joint/Muscle		**PMS**		**Dizziness**
	Heart palpitations		**Shortness of breath w/o exertion**		**Chest pain**
	Sleep problems		**Fainting spells**		**Tremors**
	Memory problems		**Hearing voices**		**Odd behavior**
	Bingeing/purging		**Anorexia**		**Hallucinations**
	Lack of self-control		**Compulsive behavior**		**Oppositional behavior**
	Problems with alcohol		**Problems with drugs**		**Blackouts**
	Unable to sit still		**Troubles at home**		**Parents Separation or Divorce**
	Difficulties with schoolwork		**Difficulties with peers**		**Parenting/ boundary issues**
	Low self confidence		**Lack of Coping skills**		**Difficulty communicating**
	Failing grades		**Sexually active**		**Poor choices in friends**
	Hearing voices		**Trust issues with parents**		**Excessive Lying**
	Procrastination		**Controlling teen relationships**		**Sexual abuse/trauma**
	Emotional abuse/trauma		**Verbal abuse/trauma**		**Physical abuse/trauma**
	Loss of a loved one		**Illness of a loved one**		**Suspicious of other people**
	Argumentative		**Immature for age**		**Violent at home or school**
	Sets fires		**Cruel to animals**		**Is easily frustrated**
	Does not sleep in own bed		**Is picked on at school**		**Unorganized**
	"Hypochondriac"		**Pouts/ sulks**		**Has run away**
	Stubborn		**Likes being in control**		**Introverted**
	Extroverted		**Likes to try new things**		**Picky eater**
	Cautious in new situations		**Neurological problems**		

Has your child ever had any surgeries? If yes, please list what procedure and when._____

_____

Has your child ever had any major illnesses? If yes, please list what and when. _____

_____

Has your child ever been hospitalized? If yes, please list for what and when. _____

_____

Does your child have any chronic illnesses? If yes, please list which and when diagnosed.

_____

Has your child ever <u>experienced</u> or <u>witnessed</u> any Sexual, Physical, or Emotional abuse? If yes, describe the circumstances._____

_____

(Circle the number that best applies)

Family Support System (such as friends, relatives, school or religious organization)

Hardly any support <u>1 2 3 4 5</u> Considerable support

How Strict are the Household Rules.

Very relaxed <u>1 2 3 4 5</u> Very Strict

How Consistent is the Follow Through on Consequences.

Not Consistent at all <u>1 2 3 4 5</u> Very Consistent

How much television does your child watch each week?

2-5 hrs. ----- 5-8hrs. ----- 8-12hrs. ----- 12-16hrs. ----- 16+hrs.

How many hours does your child spend playing non-educational video games each week?

2-5hrs. ---- 5-8hrs. ---- 8-12hrs. ---- 12-16hrs. ---- 16+hrs.