



Authentic Life

Christian Counseling

Child Information Form

Child's Information

Name _____ m / f Age _____ Date of Birth _____
School _____ City _____ Grade _____ Teacher _____

Guardian Information

Married Dating Widowed Living with partner but not married Separated/Divorced

Date of Separation/ Divorce _____

Parent Name _____ m / f Age _____ Date of Birth _____

Divorce Arrangement **Legal Custody** Joint Sole None **Physical Custody** _____
Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Parent Name _____ m / f Age _____ Date of Birth _____

Divorce Arrangement **Legal Custody** Joint Sole None **Physical Custody** _____
Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Other People in Child's Home(s)

Name _____ m / f Age _____ Relationship _____

Name _____ m / f Age _____ Relationship _____

Name _____ m / f Age _____ Relationship _____

Name _____ m / f Age _____ Relationship _____

Child Care Providers (if applicable)

Name _____ m / f Age _____ Relationship _____

Name _____ m / f Age _____ Relationship _____

Major Concerns

Please describe, in your own words, your concerns about your child and the reasons that you are seeking help.

When were these difficulties first noticed? Please explain as fully as possible. _____

Previous Professional Assistance (*with these issues*)

Agency/ Professional _____ Dates _____ Type _____

Agency/ Professional _____ Dates _____ Type _____

What matters most to your child? _____

Describe your child's strengths _____

Special Concerns

Please check any past or present concerns about your child:

- | | | | | |
|--|---|--|---|----------------------------------|
| <input type="checkbox"/> Fears | <input type="checkbox"/> Destructiveness | <input type="checkbox"/> Eating | <input type="checkbox"/> Activity level | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Coordination | <input type="checkbox"/> Temper tantrums | <input type="checkbox"/> Sexual activity | <input type="checkbox"/> Lying | <input type="checkbox"/> Truancy |
| <input type="checkbox"/> Stealing | <input type="checkbox"/> Response to discipline | <input type="checkbox"/> Fire Setting | <input type="checkbox"/> Peer Relationships | <input type="checkbox"/> Tics |
| <input type="checkbox"/> Thumb sucking | <input type="checkbox"/> Play Behavior | <input type="checkbox"/> Alcohol/Drugs | <input type="checkbox"/> Other _____ | |

Please elaborate on any concerns that you have about any of the difficulties listed _____

Describe any known neglect or abuse (physically or sexually) your child has experienced _____

Medical History

Please describe your child's general health _____

Please list **any** medication that your child currently takes and what it is for (where applicable give the name of the prescribing physician) _____

Please describe any serious illnesses, accidents, or injuries _____

Please describe any conditions that require regular medical care _____

Have any of your child's blood relatives or caretakers struggles with any of the following:

- | | | | | | | | |
|------------|------------------------------|-----------------------------|--------------------|-----------------------|------------------------------|-----------------------------|--------------------|
| ADHD | <input type="checkbox"/> yes | <input type="checkbox"/> no | Relationship _____ | Learning Disabilities | <input type="checkbox"/> yes | <input type="checkbox"/> no | Relationship _____ |
| Depression | <input type="checkbox"/> yes | <input type="checkbox"/> no | Relationship _____ | Alcohol/Drugs | <input type="checkbox"/> yes | <input type="checkbox"/> no | Relationship _____ |
| Suicide | <input type="checkbox"/> yes | <input type="checkbox"/> no | Relationship _____ | Anxiety | <input type="checkbox"/> yes | <input type="checkbox"/> no | Relationship _____ |
| Rage | <input type="checkbox"/> yes | <input type="checkbox"/> no | Relationship _____ | OCD Tendencies | <input type="checkbox"/> yes | <input type="checkbox"/> no | Relationship _____ |

Childhood History

Was your child planned/wanted? Please explain _____

Pregnancy and Birth History (please include any trauma, medication by mother, unusual emotional strain, alcohol/drug use, complications, etc.)

- Early Premature Late Caesarean Induced labor Forceps Breech Epidural

Anesthesia Blue Baby Other Medication Other complications _____

Postnatal History (Describe the time immediately following birth: feeding, incubation, injury, illness, etc.) _____

Please describe your child's ability to be soothed as a child before the age of 1 (ex. Hard to be soothed, cried a lot, slept a lot and rarely needed help being soothed, etc)

Please describe your child's academic strengths _____

Does your child prefer the company of adults to other children? Yes No
Does your child have at least one best friend? Yes No What is the friend's age? _____

How do school teachers and non-family members describe your child? _____

Family/Relationship History Please check any current struggles in the family

- | | | |
|--|---|--|
| <input type="checkbox"/> Physical health of family member(s) | <input type="checkbox"/> Marital problems | <input type="checkbox"/> Mental health of family member(s) |
| <input type="checkbox"/> Separation or Divorce | <input type="checkbox"/> Death of family member/pet | <input type="checkbox"/> Prolonged Absence |
| <input type="checkbox"/> Differences in child rearing | <input type="checkbox"/> Drinking/Drug abuse | <input type="checkbox"/> Other _____ |

Please elaborate on any concerns that you have about any of the difficulties listed _____

Briefly describe this child's behavior at home _____

How does this child get along with siblings _____

Describe any special activities that the family does together _____

Guardian Social History (Description of significant life events in guardian's family or origin i.e. discipline style, history of drug/alcohol use, employment history, legal involvement, education, moves, abuse, etc.)

Goal(s) for child's therapy and/or family change _____

Signatures of guardian(s) who completed this form

Signature

Date