Therapist:____________________________ Client Name:____________________________

SOLUTION BASED COUNSELING SERVICES, LLC
CLIENT INFORMATION PACKET – CHILD

Name of person completing this form:____

Relationship to client:_____________________________________ Who referred you to us?:______________________________

Reason child is coming in for treatment:____

____

How does your child feel about treatment?:____

What would you/your child like to achieve in counseling?:____

____

PERSONAL ADJUSTMENT

Please circle any of the following that are typical of your child's behavior:

Shy	Angry, Defiant	Moody	Panic Attacks
Quarrels	Difficulty Sleeping	Temper Tantrums	Anxiety
Sleepwalking	Sad, Cries	Soiling	Easy Going
Loner	Lies Frequently	Selfish	Speech Problems
Destructive	Poor Appetite	Sets Fire	Learning Problems
Weight Loss	Lazy/Unmotivated	Often Ill	Short Attention Span
Avoids Adults	Drug/Alcohol Use	Police Problems	Careless, Reckless
Frequent Headaches	Unusual Thinking	Messy	Enthusiastic
Bizarre Behavior	Tics or Twitches	Seizures	Overactive
Frequent Daydreams	Acts without Thinking	Generous	Suicidal Gestures
Sloppy Hygiene	Frequent Injuries	Suicide Attempts	Excessive Worries
Psychiatric Problems	Slow Moving	Bullies	Bedwetting
Expects Failure	Stealing	Overweight	Acts Out Sexually
Stomach Aches	Blinking, Jerking	Friendly	Confident
Cooperative	Obsessive or Compulsive Behavior	Clumsy	Doesn't Listen

Please explain any of the above:____

____

____

____

____

How long have these symptoms been happening?:____

____

MENTAL HEALTH TREATMENT HISTORY

Has your child ever been in Outpatient Mental Health Treatment?: ___Yes ___No When?:________________________

Where?:____

Has your child ever been in Inpatient Mental Health Treatment?: ___Yes ___No When?:______________________________

Where?:____

Have any family members ever been in Outpatient Mental Health Treatment?: ___Yes ___No Who?:___________________

Where?:____ When?:____________________________________

Have any family members ever been in Inpatient Mental Health Treatment?: ___Yes ___No Who?:___________________

Where?:____ When?:____________________________________

SCHOOL ADJUSTMENT

Name of school:______________________________________ District:____________________________________

What grade is your child in?:_____________________ Has he/she ever repeated a grade? ___Yes ___No

If so, which grade?:_____________________ Reason for repeat:____

Please describe any learning disabilities your child is experiencing:____

____

Has your child ever been psychologically tested?: ___Yes ___No If yes, when and where?___________________________

____

Has your child ever received special education services?: ___Yes ___No Please explain:_____________________________

____

How does your child relate to peers?:____

Has your child ever worked?: ___Yes ___No Any difficulties with employment?: ___Yes ___No

Please explain:____

____

CHILD'S FAMILY

	Full Name	Age	Living with you?	Deceased
Father:				
Stepfather:				
Mother:				
Stepmother:				
Siblings:				

Others in the home?:____

____

____

How does your child relate to family members?:____

Was your child adopted?: ___Yes ___No What age?:_______________ Does your child know?: ___Yes ___No

Who is the legal guardian?____

MEDICAL HISTORY

Child's Physician: Name/Office Name:____

Address:____

____

Phone Number:____

Name of preferred hospital:____

Current weight:_______________ Current height:_______________ Immunization status:_____________________________

Date of child's last exam:________________ Results:____

Any current health concerns:____

Is your child taking any medications?: ___Yes ___No Please list:____

____

Please list any allergies to medications or food:____

____

ABUSE HISTORY

Physical abuse?: ___Yes ___No What age(s)?:_____________ How long?:____________________________________

Sexual abuse?: ___Yes ___No What age(s)?:_____________ How long?:____________________________________

Verbal abuse?: ___Yes ___No What age(s)?:_____________ How long?:____________________________________

Neglect?: ___Yes ___No What age(s)?:_____________ How long?:____________________________________

DEVELOPMENTAL MILESTONES

Any physical complications during pregnancy with mother or child?: ___Yes ___No If yes, please explain:________________

____

Any substances used during pregnancy (including caffeine or tobacco)?: ___Yes ___No

Frequency/Amount of use during pregnancy?:____

Was child born premature/full term?:________________________________ Weight:_________________

Type of delivery:______________________________ Length:__________________

Age first walked:__________________ Age used single words:_________________________

Age used sentences:__________________________________ Age toilet trained:______________________________

Current language problems?: ___Yes ___No Please explain:____

Date of last hearing/eye exam:___________________________ Results:____

Has your child ever had seizures?: ___Yes ___No Any hospitalizations?: ___Yes ___No Injuries?: ___Yes ___No

Please explain:____

____

____

Any sexual orientation or gender identity concerns? ___Yes ___No

Please explain:____

____

INCOME DATA

Any financial problems in the family?: ___Yes ___No Explain:____

____

Do both parents work?: ___Yes ___No Does child attend daycare or latchkey?: ___Yes ___No

RELIGION

Any religious conflicts in the family?: ___Yes ___No Religious preference:____

Does your child practice?: ___Yes ___No Any other religious activities?:_______________________________________

____

SUBSTANCE ABUSE HISTORY

Does your child have a problem with alcohol or drugs?: ___Yes ___No

Any tobacco use?: ___Yes ___No Amount:____

Any caffeine use?: ___Yes ___No Amount:____

Other substances used:____

Age use began:____

Frequency of use:____

Date of last use:____________________________ Number of days used in the last 30 days:__________________________

LEGAL

Has your child ever been involved with the police or juvenile court system?: ___Yes ___No

Please explain:____

____

Is your child currently on probation?: ___Yes ___No Next court date:_______________________________________

Requirements of probation:____

____

Are the parents involved in a divorce or custody issue currently?: ___Yes ___No

Please explain:____

____

____

____

Additional Comments:____

____

____

____

Signature of Parent or Guardian Date

____

Therapist’s Signature /Credentials Date

Therapists Comments:____

____

____

____