

**Information Regarding Child or Teenage Client**  
*(To be completed by parent or caretaker)*

Full Legal Name \_\_\_\_\_ Current Age \_\_\_\_\_

Date of Birth \_\_\_\_\_ Approximate Weight \_\_\_\_\_ Approximate Height \_\_\_\_\_

**Custody:** Are you the child's custody holder at the present time? (Circle) Yes No Explain if Needed:

\_\_\_\_\_

**Pregnancy and birth:** Were there significant problems during the pregnancy with this child? \_\_\_\_\_

\_\_\_\_\_

Problems with delivery? \_\_\_\_\_

Was child born full-term? \_\_\_\_\_ Birth Weight/Length: \_\_\_\_\_ Apgar score: \_\_\_\_\_

**Development:** Do you think that your child developed normally as a baby? (Please describe.) \_\_\_\_\_

\_\_\_\_\_

Do you think that your child developed normally as a toddler? (Please describe.) \_\_\_\_\_

\_\_\_\_\_

At approximately what age did he/she: Speak words \_\_\_\_\_ Walk \_\_\_\_\_ Use sentences \_\_\_\_\_

Play alongside other children \_\_\_\_\_ Play cooperatively with others \_\_\_\_\_ Show empathy \_\_\_\_\_

At approximately what age was he/she toilet-trained? Daytime \_\_\_\_\_ Nighttime \_\_\_\_\_

**Sleep:** Does your child sleep in his/her own bed? \_\_\_\_\_ Does he/she have his/her own room? \_\_\_\_\_

If not, with whom does he share a room? \_\_\_\_\_

Does he/she have frequent nightmares? Bad dreams? \_\_\_\_\_

**Accidents:** Has your child had any significant injuries, blows on the head, or diseases? \_\_\_\_\_ If so, please explain:

\_\_\_\_\_

**Does your child seem to be accident-prone?** \_\_\_\_\_

\_\_\_\_\_

**Childcare:** Who takes care of your child while you are working? \_\_\_\_\_

**Medications the child is on, dosage, for what condition, and prescribing physician:** \_\_\_\_\_

\_\_\_\_\_

**What other medications has your child taken in the past for the same condition(s)?**

\_\_\_\_\_

**Schools Attended, Ending with Current One**

**Location**

**Grades Attended at Each**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Academics:** Explain how your child is doing academically at the present time, and how he/she has done in the past: \_\_\_\_\_

\_\_\_\_\_

Describe your child’s school behavior, as you understand it to be: \_\_\_\_\_

\_\_\_\_\_

Does your child finish his/her class work? \_\_\_\_\_ Homework? \_\_\_\_\_

\_\_\_\_\_

Do you believe your child has learning problems? \_\_\_\_\_ Of what nature? \_\_\_\_\_

\_\_\_\_\_

**Friends and Activities:** Does your child seem to have friends at school? \_\_\_\_\_ At home or church? \_\_\_\_\_

How does he/she seem to relate to peers? \_\_\_\_\_ To adults? \_\_\_\_\_

What does he/she enjoy doing most? \_\_\_\_\_

**Circle all of these traits/actions that apply to your child:**

- Low self-esteem      Selfish      Unwilling to share with others      Often seems unhappy      Irritable and moody
- Very shy      Doesn't reach out to others or initiate interaction with others      Is overly serious      Steals
- Lies or misrepresents things      Prefers playing alone      Is very unmotivated      Disobedient      Defiant
- Curious      Has few interests      Jealous      Dislikes school      Is angry and resentful      Disrespects authority

**If child does not live with both biological parents, what is his/her relationship with the absent parent(s)? Are there visitation arrangements? If so, what, and are they exercised? How does the child relate to any stepparent(s) involved? Do the divorced parents relate to each other well and support each other? Does the absent parent pay child support?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CKCC Checklist Regarding Your Child/Teenager**

Please enter the date of occurrence on the left and make comments on the right beside any of the problems below which your child/teenager has experienced:

- \_\_\_\_\_ Allergies: \_\_\_\_\_
- \_\_\_\_\_ High, Prolonged Fever: \_\_\_\_\_
- \_\_\_\_\_ Severe Blow to the Head: \_\_\_\_\_
- \_\_\_\_\_ Asthma: \_\_\_\_\_
- \_\_\_\_\_ Meningitis, Encephalitis: \_\_\_\_\_
- \_\_\_\_\_ Bedwetting: \_\_\_\_\_
- \_\_\_\_\_ Soiling: \_\_\_\_\_
- \_\_\_\_\_ Sleepwalking: \_\_\_\_\_
- \_\_\_\_\_ Daydreams a lot: \_\_\_\_\_
- \_\_\_\_\_ Seems to have memory problems: \_\_\_\_\_
- \_\_\_\_\_ Is "antsy" and cannot be still: \_\_\_\_\_
- \_\_\_\_\_ Poor Concentration: \_\_\_\_\_
- \_\_\_\_\_ Easily Distracted: \_\_\_\_\_
- \_\_\_\_\_ Daydreams a lot: \_\_\_\_\_
- \_\_\_\_\_ Finds it Difficult to Forgive \_\_\_\_\_
- \_\_\_\_\_ Is overly sensitive: \_\_\_\_\_
- \_\_\_\_\_ Seems disinterested in other people: \_\_\_\_\_
- \_\_\_\_\_ Bullying (Victim or Aggressor?) \_\_\_\_\_
- \_\_\_\_\_ Abuse: \_\_\_\_\_
- \_\_\_\_\_ Prolonged Separation from Parents: \_\_\_\_\_
- \_\_\_\_\_ Other Potential Traumas: \_\_\_\_\_
- \_\_\_\_\_ Eating Problems: (Type) \_\_\_\_\_
- \_\_\_\_\_ Unusual Fears or Concerns: \_\_\_\_\_
- \_\_\_\_\_ Sexual Acting Out: \_\_\_\_\_
- \_\_\_\_\_ Self Abusing Behavior: \_\_\_\_\_

\_\_\_\_\_ Trouble with Legal System: \_\_\_\_\_

\_\_\_\_\_ Gang-related activity: \_\_\_\_\_

\_\_\_\_\_ Alcohol or Drug Experimentation or Dependency: \_\_\_\_\_

\_\_\_\_\_ Death of Close Loved One: \_\_\_\_\_

\_\_\_\_\_ School Suspensions and Detentions: \_\_\_\_\_

\_\_\_\_\_ Obsessions and Compulsions: \_\_\_\_\_

\_\_\_\_\_ Continually blames others, never taking responsibility himself: \_\_\_\_\_

\_\_\_\_\_ Other (Please explain): \_\_\_\_\_

**Does the child have on-going medical issues? If so, please explain:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**What are his/her strengths?** \_\_\_\_\_

\_\_\_\_\_

**What are his/her weaknesses?** \_\_\_\_\_

\_\_\_\_\_

**How do you feel your child needs help?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Attention, Parents or Caretakers!** This form is about your child or teenager. Please be sure to download and complete the forms entitled "Information Regarding Adult Clients and Minor Client's Parents", "Agreement with Policies, Treatment, Communication", "No Show and Late Cancellation Policy", "Insurance Information", and "Symptom Checklist". **Bring them with you to your first appointment. Please call if you have questions. We look forward to getting to know you.**

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of Person Completing Form