Client Information Sheet-- Child

Name of child: ____ Age:________Date of birth:________________

Home phone: _________________________ Cell phone: ________________________________

Address: _______________________________________ City:_________________ State: _______ Zip: _____________

School: ____ Grade: ________________________

Parent's or guardian's name: ____

Parent's phone number: __________________________________

How did you hear of us? ____

Do you attend church? Yes/No If so, where? _____________________________________

Has the child had any previous counseling? Yes/No
If so, when and where? ____
Was it helpful? Yes/No Why or why not? ____

Please briefly describe what has caused you to seek counseling today for your child.

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Please describe what you hope to come from counseling. In other words, if counseling "works," how will you know?

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What kind of relationship does your child have with God?
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What does your child like to do for fun?
____

Please put a check beside any of the items below that you suspect your child may be facing:

___Depression
___Anxiety/worry
___Change in grades
___Problems at school
___Physical problems/illness
___Spiritual crisis
___Thoughts of Suicide
___Past abuse—physical, sexual, or emotional
___Current abuse--- physical, sexual, or emotional
___Substance abuse
___Anger
___Problems with parents
___Problems with friends
___Eating Disorder
___Guilt
___Loss

Is your child on any psychiatric medications? Yes/No If so, please list:

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Is there anything else you would like for me to know before we begin?

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