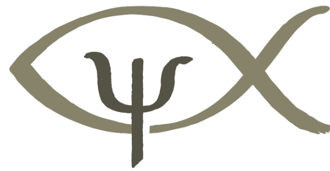

Christian Perspective
COUNSELING

Information Form For Children

To help with your child's first session, please fill out the following information as completely as you can.

Date _______________ **Child's Birthdate** _______________ **Child's SSN** ____________________

Name of Child ____
First Middle Last

Parents' Names ___________________________ ___________________________
Father Mother

___________________________ ___________________________
Step-father Step-Mother

Address ____
Street City State Zip

Phone Number (_____)_________________ **E-Mail Address** __________________________

Referred By ____
Name Relationship

Person responsible for the bill: ☐ **same as above or:**

Name ____

Address ____
Street City State Zip

Phone Number (_____)_________________

Emergency Contact

Name ____
Relationship

Address ____
Street City State Zip

Phone Number (_____)_________________

Family Information

Father's Occupation ______________________________ (____)______________
Phone Number

Mother's Occupation ______________________________ (____)______________
Phone Number

List all household members by name, age, and relationship:

1. ____
Name **Age** **Relationship**

2. ____
Name **Age** **Relationship**

3. ____
Name **Age** **Relationship**

4. ____
Name **Age** **Relationship**

5. ____
Name **Age** **Relationship**

6. ____
Name **Age** **Relationship**

Are your child's parents separated, divorced, or unmarried? ☐ **yes** ☐ **no**

Does your child see the other parent? ☐ **yes** ☐ **no**

If separated or divorced, please indicate the year and nature of the separation. ______________

____

Briefly describe your child's relationship with the other parent. ______________

____

Briefly describe your own relationship with the other parent. ______________

____

Briefly describe your child's relationship with step-parent (if applicable). ______________

____

Church Membership ______________________________

How often does the family participate in some type of religious activity? ______________

____

____

Briefly describe your family's spiritual life. ______________________________

____

____

Has your child or any member of your family ever had counseling before? ☐ **yes** ☐ **no**

If yes, describe and list counselor. ______________________________

____

What concerns you most about your child? ______________________________

____

____

When did the problem start or when did you first notice it? ______________________________

____

____

Has your child's eating or sleeping habits changed? ☐ **yes** ☐ **no**

If yes, explain. ______________________________

____

____

What would you like your child to get out of counseling? ______________________________

____

____

What have you tried so far? ______________________________

____

____

Describe your child's personality (focus on strengths). ______________________________

____

____

____

What physical and/or psychological stressors have occurred in your child's life (i.e., moves, separations, deaths, abuse, etc.)? List the age at which each event occurred. ______________________________

____

____

How does your child react to stress? ____

____

Has anyone in the extended family had a similar personality and/or problems? ☐ **yes** ☐ **no**

If yes, explain. ____

____

Does either parent use alcohol or drugs? ☐ **yes** ☐ **no**

If yes, describe frequency and type. ____

____

Is there currently a custody dispute, any litigation, order of protection, or investigation regarding this child?

☐ **yes** ☐ **no**

If yes, please describe the nature of the legal matter and its current status. ________________________

____

____

Medical Information

Is your child taking any prescription drugs at this time? ☐ **yes** ☐ **no**

If yes, list them below:

1. ____
Name **Dose** **Frequency** **Indication** **Compliant? (Y/N)**

2. ____
Name **Dose** **Frequency** **Indication** **Compliant? (Y/N)**

3. ____
Name **Dose** **Frequency** **Indication** **Compliant? (Y/N)**

4. ____
Name **Dose** **Frequency** **Indication** **Compliant? (Y/N)**

Prescribing Psychiatrist (if applicable) ________________________ (_____)________________
Phone Number

Primary Care Physician ________________________ (_____)________________
Phone Number

Does your child have any speech difficulties? ☐ **yes** ☐ **no**

Does your child have any physical handicaps? ☐ **yes** ☐ **no**

Does your child have any hearing or vision difficulties? ☐ **yes** ☐ **no**

If yes to any of the above, explain. ____

____

Does your child have any special fear? ☐ **yes** ☐ **no**

If yes, explain. ____

____

School Information

At what age did your child enter school? ___________

Did your child attend nursery school? ☐ **yes** ☐ **no**

Has your child skipped any grades? ☐ **yes** ☐ **no**

Has your child repeated any grades? ☐ **yes** ☐ **no**

Name of Current School____ **Grade**__________

List any previous schools:

1. ____
Name **Years Attended**

2. ____
Name **Years Attended**

3. ____
Name **Years Attended**

4. ____
Name **Years Attended**

How often does your child read? ☐ **none** ☐ **seldom** ☐ **average** ☐ **frequently**

What is your child's opinion of reading? ______________________________________

When your child is doing homework, do you help them? ☐ **yes** ☐ **no**

If yes, what is the nature and duration of the help? ______________________________

____

____

What subject does your child like best?_______________________ **Least?**_______________________

Health Insurance Information

Name of primary insurance company ____

Address ____

Street **City** **State** **Zip**

Policy/ID/Contract Number ____________________ **Group Number** __________________

Policy Holder ____

Name **Relationship**

___________________________ ___________________________

Birthdate **Social Security Number**

____

Address

____

Phone Number

Employer ______________________________________ **Effective Date:**________________

I authorize the release of any medical or other information necessary to process claims.

_____________________________________ __________

Client or Minor Client's Guardian Date

I authorize payment of medical benefits to Christian Perspective Counseling.

_____________________________________ __________

Signature of Policy Holder Date

_____________________________________ __________

Signature of Therapist Date