Cognitive Performance & Health

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Cognitive Performance & Health

CHILD INFORMATION FORM

Name_____ Date of 1st Appointment_____ Therapist_____

Date of Birth_____ Age_____ Right or Left Handed _____ Gender: Male_____ Female_____

Address_____ Email _____

Home Phone_____ Cell Phone_____

MEDICAL HISTORY

Name of Primary Care Physician:_____

Physician's Address:_____ Physician's Phone:_____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer:_____

Current Medication being taken:

1)_____ Dosage/Freq_____ Start Date_____ Purpose_____

2)_____ Dosage/Freq_____ Start Date_____ Purpose_____

3)_____ Dosage/Freq_____ Start Date_____ Purpose_____

4)_____ Dosage/Freq_____ Start Date_____ Purpose_____

Prescribed by:_____

Date of last medical evaluation:_____ Date of next appointment:_____

Has your child ever been hospitalized for medical or psychiatric reasons? (Circle One) YES NO

Hospital	Mo/Yr	Reason

Does your child have allergies? (Circle One) YES NO

Does your child have asthma? (Circle One) YES NO

Describe any important medical history, chronic ailments, or other health problems your child experiences:_____

_____

_____

Describe any other health problems or important medical history about your child's immediate family members and close relatives, including chronic ailments:_____

_____

_____

Does your child have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list:_____

_____

_____

Has your child ever been hit in the head, blacked out, or had a concussion? (Circle One) YES NO

If yes, how old was your child?_____ Was your child hospitalized?_____

SCHOOL AND FAMILY HISTORY

Does your child experience any developmental, academic or behavior problems while in school or daycare, with peers or teachers? (Circle One) YES NO

If yes, please explain:_____

_____

What was the last year of school your child completed?_____ What school is he/she attending?_____

Is your child home-schooled? (Circle One) YES NO

Please check all information which applies to your child's biological parents:

MOTHER		FATHER	
	_____living		_____living
	_____deceased		_____deceased
	_____married		_____married
	_____divorced		_____divorced
	_____remarried _____# of times		_____remarried _____# of times

With whom does your child live?:_____

What custody and/or visitation orders are in place?:_____

Do your child consider anyone else to be a "parent" in his/her life? (Circle One) YES NO

If so, whom?_____

Was your child adopted? (Circle One) YES NO

If yes, what was your child's age at this time?_____

Has your child ever been in foster care? (Circle One) YES NO

If yes, what was your child's age at this time?_____

List first names and ages of your child's brothers & sisters:

Name	Age	Relationship (biological, step, half, etc.)	Lives with:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Others living in the home with your child:

Name	Age	Relationship (biological, step, half, etc.)	Grade/Occupation

Describe your relationship with your child:

Currently:_____

_____

In the past:_____

_____

Describe your child's relationship with his/her other parent:

Currently:_____

_____

In the past:_____

_____

Describe any problems that have occurred in your child's family relating to:

Alcohol/drug abuse:_____

_____

Sexual/physical/emotional abuse:_____

_____

MENTAL STATUS

Please check any of the following that describe how you believe your child has been feeling lately:

_____sad _____anxious _____depressed _____frightened _____guilty _____angry _____ashamed _____aggressive _____resentful

_____worthless _____tearful _____irritable _____confused _____extreme ups/downs _____jealous _____hopeless _____helpless

_____annoyed

Describe any behaviors your child has demonstrated that cause concern.:_____

_____

Has your child had any change in sleeping habits? (Circle One) YES NO

Describe:_____

_____

Has your child had any change in eating habits? (Circle One) YES NO

Describe:_____

_____

Has your child ever **considered suicide** in connection with his/her **current** problem? (Circle One) YES NO

If so, please give a brief description with dates:_____

Has your child ever **considered suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: _____

Has your child tried to hurt others or animals recently or in the past? (Circle One) YES NO

If yes, please explain:_____

_____

LEVEL OF FUNCTIONING

Please describe what activities your child participates in:_____

_____

Who is in your child's support network?_____

_____

Please describe your child's level of physical activity:_____

_____

How much time does your child play on the computer, watch TV, or play video games?_____

_____

Please circle any of the following concerns that your child or your family may be experiencing:

Nervousness	Toileting	Suicidal Thoughts	Nightmares
Shyness	Depression	Finances	Behavioral Problems
Separation/Divorce	Sexual Problems	Unhappiness	Temper
Drug Use	Alcohol	Work	Death of a Loved One
Anger	Self-Control	Tiredness	Appetite/Eating
Sleep	Stress	Ambition	Parenting
Relaxation	Headaches	Decision Making	Stomach Trouble
Legal Matters	Memory	Concentration	Marital Problems
Energy	Insomnia	Health Problems	Loneliness
Feeling Inferior	Education/School	Other:_____	

Is there any other information regarding your child that you would like to share with your child's Therapist that is not covered on this form? You may also use this space to complete earlier responses:

_____

_____

_____

_____

_____

Please list your Therapy goals for you child:

_____

_____

_____

_____

_____

THANK YOU!