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Child Demographic Form

Instructions: Please fill out this form as completely as possible. If your child is over the age of 12, you may consider filling it out together. Please provide the most accurate information to date.

Child's Name: ____ Date: _____________

Date of Birth: ___________________ Age: _________ Grade: _________ Gender: ____________

Home Address:

____

Street City ZIP

Name of Person Completing This Form: ____

Relationship to Patient: ____________________________________

Social Security #: ____

Contact Numbers

Mother's Cellular Number: _________________________________

Mother's Work Number: ___________________________________

Mother's Email Address: ___________________________________

Father's Cellular Number: _________________________________

Father's Work Number: ____________________________________

Father's Email Address: ____________________________________

Child's Cellular Number: ___________________________________

Please circle which numbers we have permission to call and leave a detailed message with the name/phone number of our practice:

Mother: Cell Work

Father: Cell Work

Child: Cell

Other: _________________________

Referral Information

How were you referred to Therapeutic Life Counseling, PC?

____

May we have your permission to thank them? Yes No

If via the Internet, please indicate the website: ______________________________

Narrative

Please provide as detailed a narrative of what brings you, your child, and/or your family to our practice today. The more detailed you can be the more helpful this section will be in aiding you in treatment and testing. Use as many of the following lines as you need to accurately describe your needs:

____
____
____
____
____
____

What is the ***primary*** concern you have for your child at this time?

____
____
____

Does your child have any history of the following?

	Yes	No
Physical Abuse		
Sexual Trauma/Abuse		
Criminal Behaviors		
Seizures		
Psychiatric Hospitalizations		
Suicide Attempts		
Learning Problems		
Substance Abuse		
Self-Harm		
Eating Disorder		

If you marked "Yes" to any of the previous questions on the previous page (Page 2), please provide as much information as you are comfortable with about your answers. Dates of occurrences would also be helpful.

____
____
____
____

Family Information

Please provide information regarding your child's current immediate family members.

Name	Relationship	Age	How would you describe the relationship?

Is your child adopted? Yes No

If yes, at what age was your child adopted? ________________

If your child was not adopted, has your child always been raised by one or both of their biological parent(s)? Yes No

Medical Information

Present physical health problems: ____
____

Current medications: ____
____

Past medical history: ____
____
____

Your child's current pediatrician:

Name of pediatrician: ____________________________________

Phone #: ____

Fax #: ____

Other specialists that your child currently sees:

Name of specialist: ______________________________________

Phone #: ____

Fax #: ____

Name of specialist: ____
Phone #: ____
Fax#: ____

Name of specialist: ____
Phone #: ____
Fax#: ____

Sensory/Motor Information

Has your child been diagnosed with, or have symptoms of sensory integration impairments? Yes No

Does your child experience problems with wearing certain clothing? Yes No

Does your child experience problems with certain foods and/or textures? Yes No

Is your child highly sensitive to the presence of certain sounds? Yes No

Does your child experience any issues with fine or gross motor coordination? Yes No

If yes to any of the above, please describe: ____
____
____

Academic Information

Child's current grade level: _________________

Child's current school name and district: ____

Describe your child's typical grades/scores in school: ____
____

Placement: Gifted Regular Special Education Other: _____________________________

Does your child have (circle one if applicable): IEP 504 RTI Other: ___________________

Social History

Do you have concerns with your child's socialization at this time? Yes No

Describe your child's relationship with friends: ____
____
____

How would you describe your child's social abilities? _______________________________________
____

Describe your child's hobbies/interests: ____
____
____

Describe any cultural concerns for your child and/or your family: ____________________________
____

How important are religious/spiritual issues to your child? Not Important Average Very Important

Clinical Information Checklist

Below is a list of concerns that children/teenagers have sometimes. Consider each one and please provide a rating of how much each one has caused your child or your family distress in the last six months.

Concerns	Not at all		Moderate		Severe
Relationship Concerns					
Parenting Concerns					
Family Conflict					
Attention Problems					
Impulse Control Issues					
Substance Use					
Anger Issues					
Mood Swings					
Isolation					
Grief, Loss, Mourning					
Violence/Aggression					
Memory Problems					
Eating Problems					
Confusion					
Headaches					
Stomachaches					
Anxiety, Nervousness					
Obsessional Thinking					
Fears/Phobias					
Panic/Anxiety Attacks					
Nightmares/Night Terrors					
Changes in Sleep					
Traumatic Experiences					
Touchiness/Irritability					
Lack of Happiness					
Crying Spells					
Loneliness					
Loss of Energy					
Weight Gain/Loss					
Hopelessness					
Poor Appetite					
Suicidal Thoughts					
Social Problems					
Poor Grades/Learning					
Hallucinations/Delusions					

If you marked “Moderate” to “Severe” for any of the concerns on the previous page (Page 5), please provide as much information as you are comfortable with about your answers.

Is there anything more that we should know at this time about you, your family, or your child?

Thank you for taking the time to fill out this form!