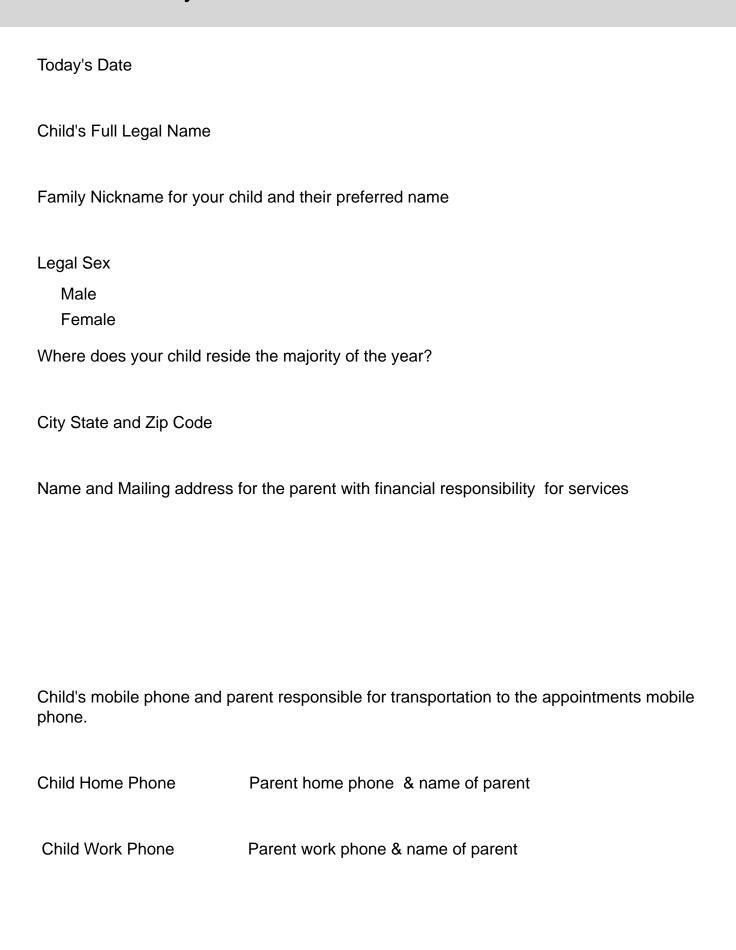
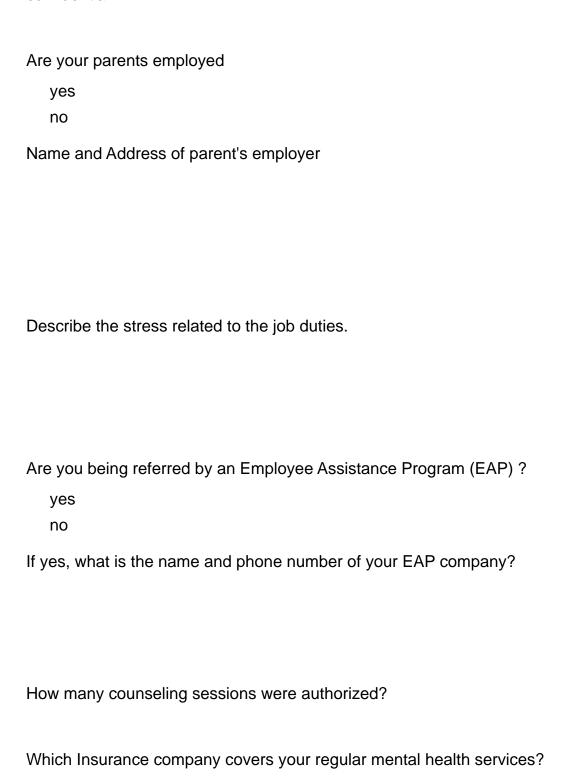
## **Child History Form**



Should I need to reach you or your parents to reschedule an appointment or to forward information, which is your preferred method of contact? Please be sure the method is confidential.



Phone number for Behavioral Health Service on the back of your insurance card.
Have you called your Insurance company to get pre-authorization for counseling?  yes  no
Social Security Number
Insurance policy number
Group policy number
Child's Date of Birth
Policy Holder's Full Name and Date of birth
How did you learn about my practice?
In the event of an emergency, who do I have permission to contact?
Emergency contact phone number and relationship to you.
Please list names/ages/relationship of everyone living in your household.

List all the losses your family or your child has experienced such as deaths, severe health changes, relationship breakups, pregnancy loss, adoptive placements, moves, etc. Please note if your child does or does not know this information.
What concerns or problems have you been experiencing which brought you into counseling at this time?

Please check any problems you feel you might be having at this time.

Difficulty falling asleep

Difficulty staying asleep

Sleeping too much

Poor appetite

Eating too much

Binge eating or purging

Drinking too much alcohol

Over use of medications or other drugs

Parent alcohol or drug use.

Other compulsions (sexual, gambling, etc.)

Suicidal thoughts

Homicidal thoughts

Problems with concentration

Health Problems

Change in moods

Racing thoughts

Relationship problems

Seeing things or hearing things that are not there

Severe financial problems

Job Stress

Gender Identify issues

Elder Care issues

Parenting issues

Angry outburst

Family violence

Child abuse or Elderly abuse

Other

Primary Health Care Provider and other providers treating current conditions.
Diagnosed health problems.

If child has been in counseling before or previous psychiatric care, please list counselors names and any positives or negatives which came about from working with a mental health professional.

List all medications, ouse.	over the counter me	edications or holisti	c remedies (supple	ments) that you

Please feel free to list any other concerns.	