Child History Form

Today's Date

Child's Full Legal Name

Family Nickname for your child and their preferred name

Legal Sex

- ◯ Male
- ◯ Female

Where does your child reside the majority of the year?

City State and Zip Code

Name and Mailing address for the parent with financial responsibility for services

Child's mobile phone and parent responsible for transportation to the appointments mobile phone.

Child Home Phone Parent home phone & name of parent

Child Work Phone Parent work phone & name of parent

Child E-mail Parent E-mail (name of parent)

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.

Are your parents employed

- ◯ yes
- ◯ no

Name and Address of parent's employer

Describe the stress related to the job duties.

Are you being referred by an Employee Assistance Program (EAP) ?

- ◯ yes
- ◯ no

If yes, what is the name and phone number of your EAP company?

How many counseling sessions were authorized?

Which Insurance company covers your regular mental health services?

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, over the counter medications or holistic remedies (supplements) that you use.

Please feel free to list any other concerns.