**PERSONAL INFORMATION FORM – CHILDREN AND YOUTH**

NAME :

ADDRESS :

MAILING ADDRESS (if different from above) :

EDUCATION:

Grade School Any Grade Level Retention? Y/N

PERSON RESPONSIBLE FOR PAYMENT: Child DOB:

PERSON WHO REFERRED YOU TO ME:

May I send a note of thanks for the referral? ( ) Yes ( ) No

FAMILY OF ORIGIN ATMOSPHERE:

Father’s Name Age Mother’s Name Age

Living ( ) Deceased ( ) Date Living ( ) Deceased ( ) Date

Address Address

Phone (H) (W) Phone (H) (W)

(C) (C)

Occupation Occupation

Employer Employer

Address Address

Birthdate Birthdate

Parents separated or divorced? No ( ) Yes ( ) Child’s age at time of separation/divorce

Did you have step-parents? No ( ) Yes ( ) Your age at time of parent remarriage

List brothers and sisters from oldest to youngest (include child coming for therapy)(Circle step-siblings)

All living? Yes ( ) No ( ) If no, name(s) of deceased and date

Which of the siblings is the child most like? How?

Which of the siblings is the child least like? How?

Which of the siblings is the child in most conflict with? Why?

Which sibling is more like Mom? How?

Which sibling is more like Dad? How?

Describe the relationship between you and your spouse.

Who makes the decisions? Do you agree on child rearing methods?

Do you disagree openly? About what?

Describe other environmental influences on the child.

Who has been important to the child (Grandparents, other relatives, friends or neighbors)?

In what way?

Do any of the family members use alcohol or other drugs? Yes ( ) No ( ) If so, to what extent?

Is this a family problem? Yes ( ) No ( ) If so, how do you cope?

Any other pertinent family history/information:

PERCEPTION OF THE CHILD:

How does the child stand out in the family?

What has he/she been successful at?

What does he/she get into trouble for?

What does the child want to be when he/she grows up?

What are the child’s responsibilities (getting self up in the morning, to sleep at night, household chores, pets, etc)?

Does the child have nightmares or dreams? Yes ( ) No ( ) How often?

What are the dreams about?

Does your child:

Get feelings hurt easily? Yes ( ) No ( ) Have any friends? Yes ( ) No ( ) Athletic? Yes ( ) No ( )

Have a bad temper? Yes ( ) No ( ) Have high standards? Yes ( ) No ( ) Follow rules? Yes ( ) No ( )

Complain/find fault? Yes ( ) No ( ) Try to please others? Yes ( ) No ( ) Acts selfishly? Yes ( ) No ( )

Do nice things for others? Yes ( ) No ( ) Help around the house? Yes ( ) No ( ) Like to be alone ( ) or with others ( )

FUNCTIONING AT LIFE TASKS:

How does child get along with adults?

Favorite adult to be with? Least favorite?

How does child get along with children in the neighborhood?

Does child prefer to play with other children of the same age, younger, or older?

How does child get along with peers at school?

Does child have a best friend? Describe him/her:

Does the friend come over very often?

How do things go for him/her at school?

What does he/she get into trouble about at school?

What do you do about it?

Does child make good grades? Yes ( ) No ( )

TRAUMA IN THE FAMILY:

What traumatic events have occurred during the child’s life (divorce, death, abuse observed, etc.)?

BEHAVIORS:

If any, what are some of the behaviors that the child engages in that are annoying to you or to other family members?

What do you do in response to these annoying behaviors?

How do you feel if these annoying behaviors persist?

What does the child do in response to discipline?

RELIGION:

Religion is: Satisfying ( ) Challenging ( ) Dull ( ) Meaningless ( ) Irrelevant ( )

HEALTH:

General Condition: Excellent ( ) Good ( ) Fair ( ) Poor ( ) Date of last physical

Physical Disabilities or Limitations:

Current Medications and Dosage:

Injury/Illness/Allergies:

Has child ever contemplated or attempted suicide? Yes ( ) No ( ) If yes, when?

Has child ever contemplated or intentionally harmed another person? Yes ( ) No ( ) If yes, when?

Sleep Pattern: Normal ( ) Restless/Broken ( ) Insomnia ( ) Oversleep/Hard to Wake ( ) Nightmares ( )

Substance Use? (Alcohol, Tobacco, Illicit Drugs) Yes ( ) No ( ) If yes, what, when, and/or how often?

PREVIOUS COUNSELING OR PSYCHOTHERAPY? Yes ( ) No ( ) If yes, when?

Received from: Phone:

PLEASE RATE CHILD’S OVERALL HAPPINESS 1-5 (1=AWFUL; 5=GREAT):

DREAMS FOR THE CHILD:

What are your hopes for the child?

Is there anything else that I should know about him/her?

PLEASE HAVE CHILD COMPLETE THE FOLLOWING SENTENCES:

Some of my strength are…

Fun for me is…

I came here today…

Six months from now…

I testify to the best of my knowledge, the information provided above is accurate and complete. I further grant permission for a Tranquil Hearts Counseling Center therapist to consult and share, should she deem it necessary, pertinent information concerning me (my child) with other professionals in order to aid my counseling/growth process.

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Client/Guardian Signature Date