**Areka D. Foster, LPCC ATR-BC**
**Art Therapy and Counseling**
116 East William
Maumee, OH 43537
Phone: 419-386-0051 www.arekafoster.com

# CHILD INFORMATION FORM

Name_____ Date of 1st Appointment_____ Therapist _____

Date of Birth _____ Age _____ Gender: Male _____ Female _____

## 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:_____

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

Current medications 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: _____

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

| Hospital | Mo/Yr | Reason |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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: _____

_____

_____

_____

**SCHOOL 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 | ____ living | FATHER | ____ 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? :_____

*** Please copy orders to be placed in client's file.**

Does your child consider anyone else to be a "parent" in his/her life? YES NO If so, whom?_ _____

Describe your relationship with your child:

Currently: _____

_____

In the past: _____

_____

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

Currently: _____

_____

In the past: _____

_____

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

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

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

Alcohol/drug abuse: _____

_____

Sexual/physical/emotional abuse:_____

_____

Others living in the home with your child:

| Name | Age | Relationship | Grade/Occupation |
|---|---|---|---|
| _____ | ____ | _____ | _____ |
| _____ | ____ | _____ | _____ |
| _____ | ____ | _____ | _____ |
| _____ | ____ | _____ | _____ |

**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

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

Has your child **attempted suicide recently** or 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: _____

_____

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 your child:

_____

_____

_____

_____

THANK YOU!