CHILD AND FAMILY INFORMATION

Today's Date:

Child Client's Name: **DOB:**

Parent's Name: **DOB:**

Parent's Name: **DOB:**

Sibling Name(s): **DOB:**

Address:

Child Cell Phone:

Parent Cell Phone: **Voice Message OK?**
Text Message OK?

Parent Cell Phone: **Voice Message OK?**
Text Message OK?

Other Phone: **Message OK?**

Email Client:

Email parent:

Email parent:

Parents' Relationship Status: \

Parents' Occupations:

Health Conditions of Client and Family Members:

Psychiatrist/ Other Mental Health Providers for Client (name and phone):

History for Client: please indicate whether this is past or present history.

ADD/ADHD:

Anxiety/ Panic:

Childhood Trauma:

Depression:

Eating Disorder/Issues:

Grief/Loss:

Relational Trauma:

Sexual Trauma:

Substance Use:

Other:

Reasons for seeking therapy: