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**CHILD INFORMATION FORM**

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Gender: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Referral: How were you referred to us?  Friend  Ad  Minister/Church  Other \_\_\_\_\_

**CHILD'S FAMILY**

<u>Name</u>	<u>Age</u>	<u>Occupation</u>	<u>Phone #'s</u>	<u>Work Schedule</u>
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Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Step-Father: \_\_\_\_\_

Step- Mother: \_\_\_\_\_

Parents currently: married \_\_\_\_ mos/yrs; separated \_\_\_\_ mos/yrs; divorced \_\_\_\_ mos/yrs; Remarried \_\_\_\_

Are there custody, visitation or any other legal issues related to this child? \_\_\_\_ No \_\_\_\_ Yes. Explain: \_\_\_\_\_

Primary residence of child: \_\_\_\_\_ Phone: \_\_\_\_\_

Secondary residence of child: \_\_\_\_\_ Phone: \_\_\_\_\_

What are the visitation residence agreements? \_\_\_\_\_

Names and ages of siblings: \_\_\_\_\_

Sleeping arrangement of child/ and how many bedrooms? \_\_\_\_\_

Religious preference \_\_\_\_\_ Church & Pastor \_\_\_\_\_

**FAMILY HISTORY**

What emotional troubles, nervous breakdowns, personality disorders, depression/anxiety, ADD/ADHD, etc have been diagnosed in the child's family or close relatives? \_\_\_\_\_

Do any of the child's blood relatives have problems similar to the child? Describe \_\_\_\_\_

What troubles have the child's family had with the law? \_\_\_\_\_

Has this child experienced or been a witness to domestic violence or high conflict within the home? Describe: \_\_\_\_\_

Has substance use or abuse (drugs or alcohol) ever been a problem with this family? Describe: \_\_\_\_\_

To the best of your knowledge, had this child ever been neglected, physically, mentally, or sexually abused?

\_\_\_\_ Yes \_\_\_\_ No. Describe \_\_\_\_\_

**HOME BEHAVIOR**

What concerns you most about this child? \_\_\_\_\_

When did the problems begin? Date: \_\_\_\_\_ Age: \_\_\_\_\_

What significant events around the same time may have contributed to the problem? \_\_\_\_\_

When are these problems worse? \_\_\_\_\_

When are they better? \_\_\_\_\_

What have you done to stop these unwanted behaviors? \_\_\_\_\_

What does this child enjoy doing most? \_\_\_\_\_

Interests/Hobbies/accomplishments of the child: \_\_\_\_\_

**SCHOOL BEHAVIOR**

School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Rate child's school performance:

<u>Grades</u>			<u>Behavior</u>		
Good	Average	Poor	Good	Average	Poor

Elementary \_\_\_\_\_

Middle School \_\_\_\_\_

High School \_\_\_\_\_

If there has been a change in academic achievement or grades, when did this occur? \_\_\_\_\_

Did the child ever have to repeat a grade? \_\_\_\_\_ Explain \_\_\_\_\_

Is child in a special class? \_\_\_\_\_ Explain \_\_\_\_\_

Describe problems child may have with peers \_\_\_\_\_

### PROBLEM CHECKLIST

Please CIRCLE any of the following that are problems with this child:

alcohol abuse	critical of self	irritable	passive	stutters
aloof	cruelty to animals	lack of focus	peer problems	suicidal gestures
always sick	depressed	lacks of empathy	phobic	suicidal thoughts
angry	disorganized	lacks respect	poor motivation	teases
anxious/worried	distrustful	limited attention	pouts/sulks	temper problems
argues	desire to please	impulsive	profanity	tense
attacks	destructiveness	lives in own world	running away	thumb sucking
avoidant	drug abuse	loud	sees vision	tics
baby talk	eating problems	low self-esteem	selfish	tiredness/fatigue
bad body image	fearful	lying	separation anxiety	toilet problems
bed wetting	feelings easily hurt	nail biting	sex problems	too mature
blames others	feels unloved	negative	shyness	un-affectionate
brags	few friends	nightmares	sleep problems	uncooperative
clumsiness	fire setting	night terrors	sleep walking	under active
common sense	guilt problems	no remorse	stealing	victim
compulsive	head banging	overly active	soiling	violent
cries easily	hears voices	overly affectionate	speech problems	wants own way
critical of others	immature	overweight	stubborn	

Please comment on anything that has not been asked, but would be helpful to know: \_\_\_\_\_

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### DEVELOPMENTAL, MEDICAL AND MENTAL HEALTH HISTORY

What problems were there during pregnancy and birth with this child? \_\_\_\_\_

Did child reach the developmental milestones (smiled, sat, crawled, walked, talked, potty trained)?

\_\_\_\_ Yes \_\_\_\_ No If there were any delays or difficulties, please describe \_\_\_\_\_

Has this child experienced any accidents, hospitalizations, chronic health problems? \_\_\_\_\_

Current health problems? \_\_\_\_\_

Name of child's current physician: \_\_\_\_\_ Physician's phone: \_\_\_\_\_

How would you rate child's overall health? \_\_\_\_\_ excellent \_\_\_\_\_ good \_\_\_\_\_ fair \_\_\_\_\_ poor

Medication currently taken by child: \_\_\_\_\_ None

Please list:

Medication	Taken since...	Prescribed by ...	For Treatment of...
_____	_____	_____	_____
_____	_____	_____	_____

Previous counseling and/or hospitalizations for behavioral, emotional or substance abuse problems?

\_\_\_\_ Yes \_\_\_\_ No. If yes, where, when and with whom? \_\_\_\_\_

IN CASE OF EMERGENCY, NOTIFY: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_