PERSONAL DATA FORM – CHILD

Person Filing this out: _____ **Today's date:** _____
Email_____

Client Name: _____
Date of Birth_____Age ___Gender (circle): M F
School: _____ Grade: ____ Special Ed:__
Contact Person:_____ Number: _____
Parent(s)/Primary caregiver(s)/Guardian:
Father's Name: _____Age____
Occupation_____
Mother's Name:_____ Age____
Occupation_____
Mailing address:
Street_____ City/State_____ Zip code_____
Telephone #'s: Home_____ Work_____ Cell_____
Email: _____
Emergency Contact:
Name:_____Relationship:_____Number:_____

May I call you and leave a message on your home phone? __No __Yes At work? __No __Yes

How did you hear about me? I would like to contact this person to thank them for the referral. If this is ok, please list their name and sign your name below.

Referred by: _____

Your Signature:_____

Present Problem
Why are you seeking psychotherapy for your child? Goals?
_____
_____
_____

Please check any of the following that currently apply to your child:

__Nightmares
__Depressed
__Lies
__Suicidal thoughts
__Homicidal ideation
__Truancy
__Low self-esteem
__Perseverates
__Angry
__Unable to make friends
__Pregnant
__Excessive guilt
__Sex Abuse
__Sleeping problems
__Negative body image
__Self-injury (i.e. cutting)
__Fire setting
__Poor school performance
__ Eating problems
__Lonely
__Worthless feelings
__Indecisive
__Hyperactive
__Poor attention
__Auditory Hallucinations
__Racing thoughts
__Forgets easily
__Anxious
__ Drug use
__Visual Hallucinations
__Stealing
__Isolates
__Running away
__Harming animals

Psychotherapy History

Please list any previous mental health services including hospitalizations in the space below:

Therapist/Doctor Dates Reason for treatment

1. _____
2. _____

Has your child ever made a suicide attempt? If yes, please describe circumstances, how and when.

_____

Has anyone in your family had psychological or psychiatric problems? If yes, please describe.

_____

Has anyone in your family had alcohol or drug problems? If yes, please describe.

_____

For teens:
Pregnant now? __No __Unsure __Yes (Due date:_____)
Abortions? __No __Yes

Is your child being seen by a psychiatrist? ____No ____Yes
If so, name of doctor: _____Number:_____

Please list all medications your child currently uses:

Name of Medication **Dosage** **Prescribed by**

_____

_____

Alcohol/Drug History: (place N/A if not applicable)
Is your child in treatment for alcohol or drug use?

_____

Please check which of the following substances you have used:

Substance	Ever used?	Used in past year?	Frequency?	Comments
Caffeine				
Tobacco				
Inhalants/Glue				
Marijuana/Hashish (pot)				
Stimulants/Amphetamines (speed)				
Sedatives/Barbituates (downers)				
Xanax/Valium/Librium (tranquilizers)				
LSD/Psychedelics/PCP (angel dust)				
Cocaine/Crack				
Heroin/Opiates				
Alcohol				

Following questions are to be filled out by your child.

Use 3 words that describe how you see yourself.
_____
_____

Favorite game and/or activities?_____
_____

Favorite foods? _____
_____

Favorite color(s)?_____

Do you have a pet? If so, what is his/her name?_____

Why are you here today?_____
_____

What would you like me to help you with?_____
_____
_____

Who are the supportive people in your life?

__Parent(s)
__Friend(s)
__Sibling(s)
__Relative(s)
__Professional caregiver
__Pet(s)
__Religious/spiritual community
__Other supportive relationship(s)

Please check off your personal strengths.

__Likable
__Appearance
__Hopeful
__Emotionally stable
__Healthy
__Adaptable
__Tolerant
__Resourceful
__Confident
__Creative
__Sensitive
__Intelligent
__Witty
__Persistent
__Loving
__Other _____

What do you like best about yourself? _____
_____