FORENSIC COUNSELING SERVICES

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CHILD INFORMATION FORM

Child's Name: _____ Gender: _____

Date of Birth _____ Age _____ Date completed: _____

Form completed by: _____ Relationship to child: _____

MEDICAL HISTORY

Name of pediatrician: _____

Address: _____

Phone: _____ Fax: _____

Last medical evaluation (date):_____ Next appointment (date): _____

Other physicians the child sees:

Name: _____ Reason: _____

Name: _____ Reason: _____

Current medications being taken (use additional pages if needed):

Medication name	Dosage and Frequency	Start Date	Purpose

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

Hospital name/location	Date	Reason

Has the child ever been in counseling/therapy for any reason? (Circle one) YES NO

Counselor/therapist name/address	Date	Reason

Has the child ever experimented with tobacco, alcohol, or other drugs? (Circle one) YES NO
If yes, please describe (including what drugs and how much/often): _____

_____

_____

Describe any important medical history, including chronic ailments, depression, anxiety, or other emotional difficulties, the child experiences: _____

_____

_____

_____

_____

_____

Describe any other health problems or important medical history about the child's immediate family members and close relatives, including chronic ailments, depression, anxiety, or other emotional difficulties: _____

_____

_____

_____

_____

_____

_____

SCHOOL AND FAMILY HISTORY

Current and past school names/locations (please list current school first)	Dates of attendance	Last grade completed

Does the child have any developmental, academic, or behavior problems? (Circle one) YES NO

If yes, please explain: _____

_____

_____

Please check all information which applies to persons who have raised the child:

Biological Mother	Biological Father	Other Who:_____	Other Who: _____
___ living	___ living	___ living	___ living
___ deceased	___ deceased	___ deceased	___ deceased
___ married	___ married	___ married	___ married
___ divorced	___ divorced	___ divorced	___ divorced
___ remarried	___ remarried	___ remarried	___ remarried

If the child lives in multiple households, please describe the current parenting time arrangements:

_____

_____

Please attach a copy of any & all current court orders regarding the child.

Describe your relationship (current and past) with the child: _____

_____

_____

_____

_____

Describe the child's relationship (current and past) with their other parent: _____

_____

_____

_____

_____

Please list the child's brothers & sisters (use additional pages if needed):

Name:		Age:	Lives with:
	Relationship (same parents, stepsibling, half-sibling, etc.):		
Name:		Age:	Lives with:
	Relationship (same parents, stepsibling, half-sibling, etc.):		
Name:		Age:	Lives with:
	Relationship (same parents, stepsibling, half-sibling, etc.):		

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

Alcohol/drug abuse: _____

_____

Sexual/physical/emotional abuse: _____

_____

Law enforcement (convictions, arrests, criminal involvement): _____

_____

DAY TO DAY FUNCTIONING

Please check any of the following that describe how you believe the 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 the child has demonstrated that concern you: _____

_____

Has the child had any change in eating or sleeping habits? (Circle one) YES NO

If yes, please describe: _____

_____

What activities or hobbies does the child participate in? _____

_____

Does the child participate in regular exercise? (Circle one) YES NO

How much time does your child spend in front of a computer, tablet, television, or other screen?

_____

Has the child ever **considered** suicide in connection to **current** problems? (Circle one) YES NO

If yes, please give date(s) and describe: _____

_____

Has the child ever **considered** suicide in the **past**? (Circle one) YES NO

If yes, please give date(s) and describe: _____

_____

Has the child ever **attempted** suicide? (Circle one) YES NO

If yes, please give date(s) and describe: _____

_____

Has the child ever tried to hurt adults, peers, or animals? (Circle one) YES NO

If yes, please give date(s) and describe: _____

_____

CURRENT CONCERNS AND GOALS

Please note any current impediments or problems in daily emotional, social, or occupational functioning (e.g. isolation from friends/family, difficulty completing daily tasks, problems between co-parents, problems at school, etc.) or other information you would like to share:

_____

_____

_____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____

_____