Bright Horizons Counseling Center, LLC
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Child Information Form

Child/Adolescent Complete Name:		Date of Birth:	Social Security#:	
Nicknames or aliases:	Age	Grade		
Home Street Address:	Apt.:	City:	State:	Zip:
Mother's Name:				
Cell phone: ☐ Preferred number	Home (evening) phone: ☐ Preferred number		Work phone: ☐ Preferred number	
Calls will be discreet, but please indicate any restrictions:				
Father's Name:				
Cell phone: ☐ Preferred number	Home (evening) phone: ☐ Preferred number		Work phone: ☐ Preferred number	
Calls will be discreet, but please indicate any restrictions:				
Who is the child's Legal Guardian?: _____				
Reason for seeking treatment at this time:				
How long have these difficulties been present?				
What are your goals for treatment?				

Child's School:	
School Address:	
School's phone #:	
School's fax#:	
Primary Teacher:	
Guidance Counselor:	

Pediatrician:	
Pediatrician's Address:	
Pediatrician phone #:	
Pediatrician fax#:	

Current Symptoms include (check all that apply):

☐ Inattention	☐ Hyperactivity	☐ Divorce	☐ Depression	☐ Anxiety	☐ Insomnia
☐ Sadness	☐ Crying Spells	☐ Impulsive	☐ Suicidal thoughts	☐ No pleasure	☐ No energy
☐ Substance abuse	☐ Pain	☐ Can't sit still	☐ Can't concentrate	☐ Eating too little	☐ Eating too much
☐ Sleep too much	☐ Mood Swings	☐ Worries too much	☐ Weight loss/gain	☐ Distrustful	☐ Self harm
☐ Sleep too little	☐ Steals	☐ Lies	☐ Fearful	☐ Explosive outbursts	☐ Past abuse
☐ Oppositional behaviors	☐ Difficulty w/transitions	☐ School/learning difficulties	☐ Fighting	☐ Obsessive /compulsive	☐ Thoughts to harm others
☐ Others:					

Mental Health History:

Previous Mental Health Treatment:			
Date(s)	Therapist/Facility	Reason for seeking treatment	Was treatment helpful?

Is the child currently prescribed medication:			
Date(s)	Medication	Reason for prescription	Was medication helpful?

Has the child been prescribed any psychiatric medications in the past?			
Date(s)	Medication	Reason for prescription	Reason Stopped

Psychiatrist name (if applicable):	
Psychiatrist Address	
Psychiatrist phone#	
Psychiatrist fax #	

Family Information

Mother		Father	
Name:		Name:	
Date of Birth/Age:		Date of Birth/Age:	
Education:		Education:	
Employer:		Employer:	
Occupation:		Occupation:	
Marital Status:		Marital Status:	
Length of Marriage		Length of Marriage	
If parents are divorced, what is the custody arrangement?			
If parents are divorced, has either parent remarried?			
Do both parents agree to this treatment/evaluation? If not, please explain:			

Siblings

Name	Age	Sex	Living at home?	
			Yes	No
Is there anyone else living at home?				

Family Relationships:

What is the child's relationship like with:	
Mother:	Father:
Sister(s):	Brother(s):
Stepparent (if applicable):	
Parent's marital relationship:	
Type of discipline in home:	
Has your child ever experienced any traumatic event (accident, death of a loved one? If yes, please describe:	
History of physical or sexual abuse, family violence or neglect? If yes, please describe:	

Family Background information:

	Yes	NO	If yes, please describe:
History of psychiatric/psychological disorders in family:			
History of substance abuse in family:			
History of suicide in the family:			
History of sexual abuse in family:			
History of violence in the family:			

Developmental History

Please fill in any information you have on the areas listed below.	
Pregnancy and Delivery:	
Prenatal medical illnesses and health care:	
Mother's age when child was born	Any complications at delivery/birth?

Neonatal care needed?

First few months of life		
Any medical conditions/allergies?		
Sleep patterns or problems:		
Child's personality as a baby:		
Milestones: at what age did your child do the following?		
Sat up:	Crawled:	Walked:
Toilet trained:	First Word:	Talked in sentences:
Any current bedwetting/toileting concerns?		
Any speech, hearing, or language difficulties?		
Need for Speech therapy or physical Therapy?		
Primary language at home:	Other language(s) spoken:	

Medical History

Date of child's last physical exam:			
At any time has your child had the following?			
Condition	No	Yes	If yes, please describe
Asthma			
Allergies			
Diabetes			
Epilepsy or seizure disorder			
Heart or blood pressure problems			
Broken bones			
Surgery			
Head injury with loss of consciousness			
Lengthy hospitalization			
Speech or language problems			
Chronic ear infections			
Hearing difficulties			
Vision problems			
Fine motor/handwriting problems			
Gross motor difficulties/clumsiness			
Appetite disturbance			
Sleep problems			
Soiling problems			
Wetting problems			
Other (please describe):			
Therapist use only: If medical condition, was a referral provided? to who: ☐ Yes ☐ No ☐ N/A			

Academic

School(s) (Name, district, address, phone)	Grade(s)	Age	Dates Attended

What kind of grades does your child usually earn? A B C D F Other:	
Child's scores on most recent standardized test (FCAT, SAT, SOL'S, etc):	
Present attitude toward school:	
Grade(s) repeated:	Reason:
Does your child have an IEP (Individualized Education Plan)?	
Placement in special classes?:	
Describe school behavioral problems:	
Describe relationship with teachers:	
Describe relationship with peers:	
Please list your child's Extracurricular activities:	
List hobbies, sports; recreational, TV, and toy preferences; etc.:	

Legal History

Has your child had any type of legal involvement? If yes, please describe:

Other:

Please list some of your child's strengths:
Please list some of your child's weaknesses:
Is there anything else I should know that doesn't appear on this form or other forms, but that is or might be important?

My signature below indicates that I have voluntarily and accurately completed the Form. A photocopy of this agreement will be considered as valid as an original.

Client name	Signature of Client/Parent or Guardian	Date
Witness name	Signature of Witness	Date

Child Checklist of Characteristics

Name: _____ Date: _____

Age:_____ Person completing this form: _____ Relationship to child:_____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- ☐ Affectionate
- ☐ Argues, "talks back," smart-alecky, defiant
- ☐ Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
- ☐ Cheats
- ☐ Cruel to animals
- ☐ Concern for others
- ☐ Conflicts with parents over rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
- ☐ Complains
- ☐ Cries easily, feelings are easily hurt
- ☐ Dawdles, procrastinates, wastes time
- ☐ Difficulties with parent's paramour/new marriage/new family
- ☐ Dependent, immature
- ☐ Developmental Delay
- ☐ Disrupts family activities
- ☐ Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
- ☐ Distractible, inattentive, poor concentration, daydreams, slow to respond
- ☐ Dropping out of school
- ☐ Drug or alcohol use
- ☐ Eating-poor manners, refuses, appetite increase or decrease, odd combinations, overeats
- ☐ Exercise problems
- ☐ Extracurricular activities interfere with academics
- ☐ Failure in school
- ☐ Fearful
- ☐ Fighting, hitting, violent, aggressive, hostile, threatens, destructive
- ☐ Fire setting
- ☐ Friendly, outgoing, social
- ☐ Hypochondriac, always complains of feeling sick
- ☐ immature, "clowns around", has only younger playmates/friends
- ☐ Imaginary playmates/friends, fantasy
- ☐ Independent
- ☐ Interrupts, talks out, yells
- ☐ Lacks organization, unprepared
- ☐ Lacks respect for authority, insults, dares, provokes, manipulates
- ☐ Learning disability
- ☐ Legal difficulties - truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
- ☐ Likes to be alone, withdraws, isolates
- ☐ Lying
- ☐ Low frustration tolerance, irritability
- ☐ Mental Retardation
- ☐ Moody

- ☐ Mute, refuses to speak
- ☐ Nail biting
- ☐ Nervous
- ☐ Nightmares
- ☐ Need for high degree of supervision at home over play/chores/schedule
- ☐ Obedient
- ☐ Obesity
- ☐ Overactive restless, hyperactive, out-of-seat behaviors, fidgety, noisiness
- ☐ Oppositional, resists, refuses, does not comply, negativism
- ☐ Prejudiced, bigoted, insulting, name calling, intolerant
- ☐ Pouts
- ☐ Recent move, new school, loss of friends
- ☐ Relationships with brothers/sisters or frieinds/peers are poor - competition, fights, teasing/provoking, assaults
- ☐ Responsible
- ☐ Rocking or other repetitive movements
- ☐ Runs away
- ☐ Sad, unhappy
- ☐ Self-harming behaviors - biting or hitting self, head banging, scratching self
- ☐ Speech difficulties
- ☐ Sexual - sexual preoccupation, public masturbation, inappropriate sexual behaviors
- ☐ Shy, timid
- ☐ Stubborn
- ☐ Suicide talk or attempt
- ☐ Swearing, blasphemes, bathroom language, foul language
- ☐ Temper tantrums, rages
- ☐ Thumb sucking, finger sucking, hair chewing
- ☐ Tics - involuntary rapid movements, noises, or word productions
- ☐ Teased, picked on, victimized, bullied
- ☐ Truant, school avoidant
- ☐ Underactive, slow-moving or slow-responding, lethargic
- ☐ Uncoordinated, accident-prone
- ☐ Wetting or soiling the bed or clothes
- ☐ Other characteristics or issues:

  _____

  _____