EXHALE
counseling
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Child and Adolescent Form
Client Information Form

Today's date: _____

Your child's name: _____
Last **First** **Middle Initial**

Parents' or Legal Guardians' Names: _____
Parent 1 **Parent 2**

Child's date of birth: _____ **Gender:** _____

Home street address: _____

City: _____ **State:** _____ **Zip:**_____

Parent or Legal Guardian's Name of Employer: _____

Home Phone: _____ **Work Phone:** _____
Cell Phone: _____ **Email:** _____
Calls will be discreet, but please indicate any restrictions:_____
_____

Referred by: _____
- May I have your permission to thank this person for the referral?
  ☐ **Yes** ☐ **No**
- If referred by another clinician, would you like for us to communicate with one another?
  ☐ **Yes** ☐ **No**

Person(s) to notify in case of any emergency: _____
Name **Phone**
We will only contact this person if we believe it is a life or death emergency. Please provide your signature to indicate that we may do so: (Your Signature):_____

Please briefly describe your child's presenting concern(s):_____
_____
_____

What are your/your child's goals for therapy? _____
_____
_____

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses your child has had:_____
_____
_____
_____

Current Medications (if you need more room, please write on the back of this page):

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous medical hospitalizations (Approximate dates and reasons): _____
_____
_____

Previous psychiatric hospitalizations (Approximate dates and reasons): _____
_____

Has your child ever talked with a psychiatrist, psychologist, or other mental health professional? (If yes, please list approximate dates and reasons): _____
_____
_____

FAMILY:

How would you describe your child's relationship with his or her mother?_____
_____
_____

How would you describe your child's relationship with his or her father?_____
_____
_____

Are the child's parents still married or did they divorce?_____ If they divorced, how old was the child when the parents separated or divorced and how do you think this impacted him or her? _____
_____

How many sisters does your child have? _____ Ages? _____

How many brothers does your child have? _____ Ages? _____

How would you describe your child's relationships with his or her siblings?_____
_____
_____

SOCIAL SUPPORT & EDUCATION:

Child's current level of satisfaction with friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

How would you describe your child's relationships with his/her peers? _____
_____

Please briefly describe any history of abuse, neglect and/or trauma: _____
_____
_____

Please briefly describe your child's self-care and coping skills: _____
_____
_____

What are your child's diet, weight, and exercise/activity patterns?_____
_____
_____

Please briefly describe your child's school performance and experience:_____
_____
_____

What are your child's hobbies, talents, and strengths?_____
_____
_____

Is your child involved In any faith based activities or
groups?_____

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD & ***CIRCLE*** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety →			Tantrums →			Nausea →		
Depression			Parents Divorced			Stomach Aches		
Mood Changes			Seizures			Fainting		
Anger or Temper			Cries Easily			Dizziness		
Panic			Problems with Friend(s)			Diarrhea		
Fears			Problems in School			Shortness of Breath		
Irritability			Fear of Strangers			Chest Pain		
Concentration			Fighting with Siblings					
Headaches			Issues Re: Divorce			Sweating		
Loss of Memory			Sexually Acting Out			Heart Problems		
Excessive Worry			History of Child Abuse			Muscle Tension		
Wetting the Bed			History of Sexual Abuse			Bruises Easily		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Makes Careless Mistakes		
Separation Anxiety			Hurting Self			Fidgets Frequently		
Alcohol/Drugs			Thoughts of Suicide			Impulsive		
Drinks Caffeine			Sleeping Too Much			Waiting His/Her Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Head Injury			Sleeping Alone			Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems		Physical Abuse		Depression			
Legal Trouble		Sexual Abuse		Anxiety			
Domestic Violence		Hyperactivity		Psychiatric Hospitalization			
Suicide		Learning Disabilities		"Nervous Breakdown"			

Any additional information you would like to include:

_____

_____

_____