Client/Patient Name: _____ D.O.B. _____

Person(s) with legal custody of child:

Name _____

☐ Biological Parent ☐ Adoptive Parent ☐ Step Parent ☐ Foster Parent ☐ Other _____

Address (if different from child's): _____

_____

Contact Numbers: (H)_____ (W)_____ (Other)_____

Age_____ Highest Grade Completed_____ Religion_____

Place of work_____ Type of work_____

Work days/hours_____

Presently married ☐ Yes ☐ No Previously married: ☐ Yes ☐ No

Name _____

☐ Biological Parent ☐ Adoptive Parent ☐ Step Parent ☐ Foster Parent ☐ Other _____

Address (if different from child's): _____

_____

Contact Numbers: (H)_____ (W)_____ (Other)_____

Age_____ Highest Grade Completed_____ Religion_____

Place of work_____ Type of work_____

Work days/hours_____

Presently married ☐ Yes ☐ No Previously married: ☐ Yes ☐ No

Child's natural parents if not listed above:_____

_____

Reason for not living with child: _____

_____

Child's Medical History

	YES	NO	Describe:
Medical problems during pregnancy?			
Medications during pregnancy?			
Did either parent drink much alcohol or use other drugs during pregnancy?			
Other problems during pregnancy? (marital, job, money, living conditions)			
Birth weight:			
Was child born premature?			How premature?
Problems with newborn period or infancy? (being born blue, birth defects, yellow jaundice, seizures, infections, injuries, feeding problems)			
Was or is child allergic to medications or anything else?			

Client/Patient Name: _____ D.O.B. _____

Child's Temperament

	Yes	No	Describe
Is your child overactive?			
Does you child have trouble paying attention?			
Does your child have trouble staying with an activity?			
Does your child fluctuate from happy to sad quickly with little apparent cause?			
Does your child get frustrated easily?			
Are your child's emotional responses generally unpredictable?			
Does it take your child a long time to warm up to new situations or people?			
Does your child react strongly to physical pain?			
Does your child react strongly to other things?			

Child's School History

	Yes	No	Describe
Has your child had learning problems?			
Has your child had social problems in school?			
Is your child receiving special help at school?			
Any other school concerns?			

Child's School: _____ Grade: _____

Teacher(s): _____

504: _____

IEP: _____

School Counseling: _____

Other: _____

End of client completed form

Reviewed with client:

Marc D. Richter, LICSW, LADC: _____

Signature: _____ *Date:* _____