4 W. Rolling Crossroads Ste 3 Catonsville, MD 21228 • 443-292-6722 • www.HealASista.com

CLIENT INFORMATION FORM (CHILD)

DATE COMPLETED: _____

The information requested is to help me get to know you and your child to serve you best. Please fill out this form as completely as you can. All information will be held in strict professional confidence unless otherwise directed by law.

Basic Information: Child/Adolescent

FULL NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY #: _____

EMAIL ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

BY WHICH NUMBER IS THE BEST TO REACH YOU? ☐ HOME ☐ CELL

NAME OF SCHOOL: _____

GRADE LEVEL:_____

DOES YOUR CHILD HAVE CHALLENGES IN SCHOOL? ☐ YES ☐ NO

IF YES, PLEASE GIVE DETAILS:

_____

_____

DOES YOUR CHILD HAVE AN IEP? ☐ YES ☐ NO CAN YOU PROVIDE A COPY? ☐ YES ☐ NO

(FOR ADOLESCENTS) IS YOUR TEEN EMPLOYED? ☐ YES ☐ NO

IF YES, LIST EMPLOYER: _____

Basic Information: Parent/Guardian

FULL NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY #: _____

EMAIL ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

BY WHICH NUMBER IS THE BEST TO REACH YOU? ☐ HOME ☐ CELL

Can I send you a TEXT message for scheduling purposes only? ☐ YES ☐ NO

I cannot guarantee confidentiality when you and I communicate via telephone, fax, or email. These devices could compromise confidentiality. By understanding the inherent risks of the aforementioned devices, you can make an informed choice about when / where / how to use those tools.

In case of an emergency, who would you like me to contact? _____

Relationship to you: _____

OCCUPATION: _____

LEVEL OF EDUCATION: ☐ HS Diploma/GED ☐ 2-year college ☐ Bachelor's Degree ☐ Master's ☐ PhD

EMPLOYER: _____

Referral Information

How did you learn about Kindred Wellness? _____

May I send a thank you note to your referral source? ☐ YES ☐ NO

Can I mention your name? ☐ YES ☐ NO

Health Information for Child/Adolescent

Primary Care Physician (PCP): _____

Phone Number: _____ Last PCP Visit: _____

What was the reason for your child's PCP visit? _____

_____

Serious illnesses, injuries, or surgeries: _____

_____

_____

Does your child have any conditions or disabilities that I need to be aware of? _____

_____

_____

Current health concerns*(if any)*: _____

_____

_____

If your child uses alcohol or drugs that are **NOT** prescribed, please list the name, how much, and how often:

_____

Please list all prescribed and over-the-counter medications that your child is currently taking and why: _____

_____

_____

_____

How much does your child exercise? What is their regular diet? _____

_____

_____

Has your child ever worked with a Mental Health Professional? □ **YES** □ **NO**

If so, who? _____

Address & Phone Number: _____

_____

Last seen? _____ Why? _____

Has your child ever worked with a Psychiatrist? □ **YES** □ **NO**

If so, who? _____

Address & Phone Number: _____

_____

Last seen? _____ Why? _____

Have they ever tried to harm themselves or anyone else to your knowledge? □ **YES** □ **NO**

If so, when and how many times?_____

_____

Has your child ever been the victim of physical, mental, sexual abuse? □ YES □ NO

If so, when?_____ Where? By whom?_____

Was this investigated by a State Agency or Dept of Social Services/CPS? □ YES □ NO

Has your child ever had case management services from the Department of Social Services? □ YES □ NO

If so, When?_____ Where? _____

Why? _____

Has your child ever been hospitalized for mental, chemical, or emotional problems? □ **YES** □ **NO**

If so, when?_____ Where? _____

Why? _____

Has your child ever worked with a life coach or mentor? □ **YES** □ **NO**

If so, who? _____

Address & Phone Number: _____

Last seen: _____Why? _____

Please list all household members, relation and age:

_____

_____

_____

Are there any other caregivers for your child, not already listed? □ **YES** □ **NO**

If yes, please list: _____

Other relevant information: _____

_____

_____

Goals of Counseling

What would you like to change about your child's behaviors/development? _____

_____

_____

How has this been a problem? _____

_____

_____

When did this problem first appear? _____

_____

What changes have you noticed recently? _____

_____

_____

How have you or your child tried to solve this problem? _____

_____

_____

Why are you seeking help right NOW? _____

_____

_____

How will you know when the problem is solved? _____

_____

Who will benefit most from solving this problem? _____

_____

_____

Who might be the first to notice improvement? _____

_____

_____

Tell me about your family/child's spiritual / religious beliefs. _____

_____

_____

_____

Tell me the concerns/fears you have about your child. _____

_____

_____

_____

Hobbies / interests: _____

_____

_____

Change is usually difficult. In the past, what **strengths and skills** would you say your child has? ***They will be helpful in solving this problem***. _____

_____

_____

_____

_____

My signature below signifies that the abovementioned information is true and accurate to the best of my ability and knowledge.

_____ _____

Parent Signature Date

FOR OFFICE USE ONLY:

□**OOP**□**OON**