# Client Information Form

***This is a strictly confidential record. Information contained in it will not be released to anyone, unless authorized by you or required by the law as explained in the consent to treatment. Please compete and bring with you to your first appointment or mail to Paulette Clark, 23792 Rockfield Blvd, Suite 290, Lake Forest, CA, 92630 (949) 313-1093

Today's Date_____ Referred by _____

**Parent: Please provide the following information:**

Patient's (Minor) Name: _____ Sex: Male____ Female ____

Date of Birth: _____ Age: _____

Grade Level:_____ School:_____

Biological Mother:_____ Biological Father:_____

If Adopted, Adoptive Mother:_____ Adoptive Father:_____

Child's Home Address: _____

Child's Home Phone: (_____)_____ Child's Cell Phone: (_____)_____

Child's E-mail Address:_____

If living situation involves custody arrangements, please give detail of custody and living arrangement: (Is non-attending parent aware this child is in therapy?) _____

**RESPONSIBLE PARTY**

Parent responsible for Payment:

Name _____ Date of Birth: _____Age: _____

Address _____ Method of payment?_____

Home Phone: (____)_____ Cell Phone: (____)_____

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Please give a brief description of the problem(s) you would like help with?

What are the primary areas of concern regarding your FAMILY?

**Spiritual**

- As a family, how do you define your spiritual belief system? Church affiliation, if any:

- Would you like spirituality/religious issues to be a part of your child's therapy? Y /N / Would like to discuss this/Don't Know

**Parent and Family Treatment History**

- Parent: Please describe **yourself** as a child. What messages did you receive directly or indirectly from your parents (or other significant caregivers) about yourself (e.g., "you're special," "you're a burden," "you're not important/loveable," etc.). How did you respond to these messages? Do you think they still impact you today? If so, in what way? If not, why not? Give an example of a time when you needed comfort as a child. To whom did you turn? How did they comfort you? Did you experience relief or not? If you had to comfort yourself, how did you do this and with what effect?

- Have you explored treatment options for yourself as the parent or anyone else in the family? Yes/ No If no, why not? If yes, what kind, when, for what, and with what results?

- Parent: In general, on a Scale of 1 to 10, with ten being the most stressful, how stressful was the home **you** grew up in? Why? Specifically, which developmental period was the most difficult (i.e., early childhood, grade school, preteen, teens, 20's, etc.)? Why? (Once again, do not be brief.)

- Parent: Please describe your current emotional state:

## Child/Teen History

**Significant Developmental Events of child** (include marriages, separations, divorces, deaths, traumatic events, losses, etc.)

**Current Marital Situation/Satisfaction of Biological Parents:**

**Biological Mother's History**: Living: Age _____; Deceased: Age _____; Cause of death _____

- # of Marriages ___ Highest Level of Education: _____Occupation: _____
- Learning problems:
- Behavior problems:
- Medical Problems:
- Has mother ever sought psychiatric treatment? Yes /No If yes, for what purpose
- Patient's mother's alcohol/drug use history
- Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, or psychiatric hospitalizations? (specify)

**Biological Father's History**: Living; Age _____ Deceased: Age _____ Cause of death _____

- # of Marriages ___ Highest Level of Education: _____Occupation: _____
- Learning problems:
- Behavior problems:
- Medical Problems:
- Has father ever sought psychiatric treatment? Yes No ___ If yes, for what purpose?
- Patient's father's alcohol/drug use history
- Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, or psychiatric hospitalizations? (specify)

**Step or Adopted Mother's History (indicate which)**: Living: Age ____ Deceased: Age ____

- # of Marriages ___ Highest Level of Education: _____Occupation: _____
- Learning problems
- Behavior problems
- Medical Problems
- Has step or adopted mother ever sought psychiatric treatment? Yes____ No ___ If yes, for what purpose?

- Patient's step or adopted mother's alcohol/drug use history

**Step or Adopted Father's History (indicate which)**: Living: Age ____ Deceased: Age ____

- # of Marriages ___ Highest Level of Education: _____Occupation: _____
- Learning problems
- Behavior problems
- Medical Problems
- Has step or adopted father ever sought psychiatric treatment? Yes ____ No ___ If yes, for what purpose?

- Patient's step or adopted father's alcohol/drug use history

## CHILD'S DEVELOPMENTAL HISTORY

**PRENATAL EVENTS:**

- Was pregnancy planned? Yes /No Parents' emotional reaction to pregnancy?

- Describe any stress during pregnancy?

- Describe any postpartum anxiety or depression? How long?

- If mom was working, how soon after birth did she go back to work and under what circumstances?

- Is the child adopted? Yes____ No ____ If Yes, give the age at the time of adoption:

- Describe all placements/care prior to adoption (e.g., with bio family member, foster care, early failed adoption, etc.). What were the circumstances and experiences in care?

- Have there been any physical or emotional separations? (i.e., death, hospitalizations, depression) between child and care taking adult, especially during the first 26 months of life? Yes/ No If yes please describe:

**BIRTH AND POSTNATAL PERIOD:**

- Birth weight _____; Length _____ ; Labor duration _____; Delivery: vaginal /C section
- APGAR scores (if known) _____; Any jaundice? Yes \ No; Length of time in hospital: _____
- Complications? (Please include information about forceps or vacuum delivery, compressed cord or cord around the neck, blue appearance, not breathing, fetal distress, etc.)

- Mother's health after delivery: Physical problems?

- Primary caretaker for child, first year? Thereafter?

**EDUCATIONAL INFORMATION**:

- Grade in school ____ Are classes Regular, Special Education, or Gifted? Describe any learning disorders.

- Did the child skip a grade or get held back? If so, which one and why?

- Describe any problems or concerns regarding school, homework, classroom performance, learning disabilities, etc.

**MEDICAL INFORMATION:**

- Present Height _____ Present Weight _____

- Please provide a history of your child's self harm (cutting, burning, etc.) or attempted suicide(s)? Please give details and dates. Is your child currently suicidal or does he/she practice self harm?

- Describe any head injury, serious illness, accident, medical trauma, or surgery. (e.g., unconscious, high fever, seizures, colic, etc.)

- Please describe any speech or hearing problems, any physical limitations, and/or any nervous habits.

- Describe exercise habits, including type of exercise and frequency of workouts.

**Past/Present Psychiatric Medications:**

Please list all medications for your child. If you have tried alternate medications, please include:
1. The name of the medication
2. The mg, dose
3. The amount of tablets or mg you took in one day
4. The approximate dates taken – preferably in sequential order
5. Whether the medicine worked well, worked partially, or didn't work at all.
6. If you took any medications in combination with other medications
7. Any side effects or adverse effects from the medication

(*If you need more room, please attach another sheet.)*

| **Date Taken** | **Medication** ***Individual or Combinations Dosage(s) and time(s) taken per day*** | **Effectiveness** | **Side-Effects/Problems** |
|---|---|---|---|
| **Ex:** 3/2000- 12/2005 | **Example**<br>• *Ritalin 5 mg BID*<br>• *Prozac 10mg QAM* | **Example** *Improved concentration in morning, still moody* | **Example** *Very unfocused and hyperactive* |
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**MEDICAL CONDITIONS** (Please check all that apply):

| SYMPTOM | NEVER | SELDOM | SOMETIMES | OFTEN | ADDITIONAL COMMENT |
|---|---|---|---|---|---|
| Insomnia | | | | | |
| Loss of Appetite | | | | | |
| Back Pain | | | | | |
| Asthma | | | | | |
| Headaches | | | | | |
| Phobias (Fears) | | | | | |
| Nausea | | | | | |
| Allergies | | | | | |
| Nervousness | | | | | |
| Loss of temper | | | | | |
| Fatigue | | | | | |
| Depression | | | | | |
| High blood pressure | | | | | |
| Constipation | | | | | |
| Diarrhea | | | | | |
| Over-eating | | | | | |
| Mood swings | | | | | |
| Self-harm Behaviors | | | | | |
| Hearing/Seeing things that are not there | | | | | |

**Diet History:**

- Age breastfeeding was weaned _____ ; Age bottle-feeding was weaned _____
- Would you currently consider your child's diet to be mostly healthy or unhealthy?

- Is your child currently on a restricted diet (i.e. vegetarian, high protein only, etc)? Yes /No If yes, please list restrictions:

- Any experience with a gluten free diet? Yes /No ___ If yes, please list results:
- Any experience with a casein free diet? Yes/ No ___ If yes, please list results:
- Caffeine consumption per day (i.e. coffee, soda, tea, chocolate):

- Does your child have any allergies? Yes/ No If yes, please list and tell how they are being treated.

**Sleep Behavior:**

- Any problems falling asleep? Yes/No If yes, please describe why your child has a hard time going to sleep and how long on average it takes for them to fall asleep:

- Any problems staying asleep? Yes/No If yes, please describe why your child wakes in the night and explain if they are able to fall asleep again, and how quickly:

- Any problems waking up? Yes/No
- On average, how many hours does your child sleep per night?
- Any history of bedwetting, sleepwalking, recurrent dreams, sleep apnea, heavy snoring, or sleep bruxism (grinding your teeth)?

**CHILD'S DEVELOPMENT HISTORY:**

**Toilet training:**

- Age reached bowel control: day _____ night _____; bladder control: day _____ night _____. Please describe any difficulties or delays:

**Sexual development:**

- Gender identity. Please list any problems?
- Is your child sexually active or demonstrating inappropriate sexual behavior? Yes / No If yes, give additional information:

**Physical/Sexual Abuse:** Please give the history of anything that has happened to your child that you would consider being physically, emotionally or sexually abusive.

**Motor development:**

- (Please write in age. Parentheses are approximate normal limits.) rolls over (3-5m)____; sit without support (5-7m)_____; crawls (5-8)_____; walks well (11-16m)_____ ; runs well (2y_____; rides tricycle (3y)_____; throws ball overhand (4y)____
- Current level of activity/exercise:

**Language development:**

- (Please write in age. Parentheses are approximate normal limits.) several words besides dada, mama (1yr.)_____; name several objects-ball, cup (15m)_____; 3 words together--subject, verb, object (24m) _____;
- Please rate vocabulary (excellent, good, average, poor) _____; articulation _____; comprehension _____
- Compared to peers:
- Current problems:

**Social development:**

- (Please write in age. Parentheses are approximate normal limits.) smile (2m) ____ shy with strangers (6-10m) ____separates from mother easily (2-3y) ____cooperative play with others (4y)____
- Quality of attachment to mother as child:
- Quality of attachment to father as child:
- Relationships to family members:
- Describe relationships with parents/caregivers and authority figures (e.g., teachers, small group leaders, etc.).
- Early peer interactions:
- Current peer interactions:

**Behavioral/Discipline:**

- Child's behavior is compliance/Non-compliance? Please give examples, lying, stealing, rule breaking, etc. Describe any violent behavior, cruelty to animals, and/or preoccupation with fire.
- Methods of discipline:
- Other problems:

**Emotional development:**

- Early temperament:

- Current personality:

- Current emotional mood. If anxious or depressed, please give approximate age at which this began, occurrences and reoccurrences:

- Fears/phobias:

- Special objects (blankets, dolls, etc.)
- Ability to express of feelings?

**Drug/Alcohol History:**

- Do you know of (or suspect) the use of illegal drugs, cigarettes, alcohol, or marijuana? If so, what has been used? About how much and how often, and under what are the circumstances?

- Does your child have an addiction?

**Legal History:** Any arrests or probations? Yes /No Please describe reason for arrest and give information about how it was handled.

**GENERAL INFORMATION:**

- Describe your child's interests, the activities, and types of recreation enjoyed.

- Special interests/hobbies

- Describe your child's strengths and talents:

- Please list 3 goals for coming to therapy:

## GENERAL CONSENT TO THERAPY

I consent to counseling, psychotherapy and diagnostic testing for my child/teen as prescribed by the therapist. I agree to be responsible for the payment of $145 per session (45/50 minutes) which is payable at the time of the session. I understand that I am responsible for payment, even though I may be reimbursed by my insurance company. I also understand the "no cancel" policy and that any missed appointments will be charged at the agreed upon rate. The appointment may be rescheduled for no charge at another time. Only one "missed appointment" is eligible to be rescheduled at a given time. In the case there are two missed appointments, the earliest appointment will be cancelled.

Parent/Guardian _____ Date _____