CONFIDENTIAL CLIENT QUESTIONAIRE (CHILDREN)

Please fill out this form for your child and bring it to their first session. Please note: All information you provide here will remain confidential.

Child's Name:_____

Child's Birth Date: _____ /_____ /_____ Age: _____

Mailing
Address:_____

Parent(s) Name(s)_____

Parent(s) Phone Numbers:

Home: _____ May I call you here? Yes No

Cell: _____ May I call you here? Yes No May I text you here? Yes No

E-mail: _____ May I email you? Yes No

Parent(s) profession(s):_____

Parent(s) Relationship Status: Single, Partnered, Married, Separated, Divorced, Widowed

Custody arrangement (if applicable):_____

Members of
household(s):_____

Names/ages of other children in the family: _____

Emergency Contact Name: _____ Number: _____

Child's School Name and
Grade/Teacher:_____

May I contact your child's teacher? Yes No Signature:_____

Name of Child's Primary Physician & Phone Number: _____

Other therapies child is receiving (cranial sacral, speech, etc.):

_____

May I contact your child's health providers? Yes No Signature:_____

How would you describe your child's current physical health?
Poor Unsatisfactory Satisfactory Good Very good

Did child's pregnancy or birth include any complications (prolonged labor, etc.): Yes No

If yes, please explain:_____

Please list any specific health problems your child is currently experiencing:

Is your child currently taking any prescribed medications or supplements? If yes, please identify the medications.

Please indicate any of the following that your child (or other family member) is experiencing:

SYMPTOM	CHILD	OTHER FAMILY MEMBER (Please specify person)
Anxiety		
Panic attacks		
Stress		
Eating Issues		
Anger		
Depression		
Life transition		
Health problems		
Fatigue		
Fears/phobias		
Grief		
Self-control issues		
Sensory issues		
Social challenges		
Loss of motivation		
Spiritual questions		
Sleep issues		
Relationship challenges		
Lack of interest/apathy		
High sensitivity		
Appetite/weight change		
Attention issues		
Learning issues		
School challenges		
Discipline issues		
Nervous habits		
Change in personality		
Digestion issues		

Does either parent have a history of childhood trauma or abuse/neglect? Yes No Maybe

Parent(s) alcohol/drug use? Never Rarely Monthly Weekly Daily

Does or has child experienced physical punishments (spanking)? Yes No

Has child mentioned suicide/self-harm? Frequently Sometimes Rarely Never

Does your home contain a weapon? Yes No

Do you have any family history of mental or physical health problems? Please identify family member and diagnosis.

What significant life changes or stressful events has your child and/or family experienced in the past year?

What are your child's strengths?

What are your goals for your child from our work together?

How did you hear about my practice?

Is there any additional information you think it would be helpful for me to know as we begin to work together (feel free to use the back of this sheet)?