Client Information - Child

Date: _____

Parent or guardian name(s): _____

Child name: _____ DOB: _____

Address:(street)_____(city)_____(zip)_____

Phone numbers: May I leave a voice mail or send a text at this number?

Cell: _____ yes no

Home: _____ yes no

Work: _____ yes no

Email: _____

Emergency contact: _____ Phone: _____

How did you find out about my services? (circle all that apply)

My website Psychology Today online Google Ad

Personal referral (who?) _____

Other family members:

name _____ age _____ relation to client _____

name _____ age _____ relation to client _____

name _____ age _____ relation to client _____

name _____ age _____ relation to client _____

name _____ age _____ relation to client _____

Please circle any of the following that apply to your child:

Depression	Compulsive behaviors	ADHD
Anxiety/Worry	Grief or loss	Sexual abuse
Panic attacks	Parental divorce	Physical abuse
Eating disorder	Parental death	Trauma or PTSD
Mood swings	Anger outbursts	Self-esteem issues
Obsessive thoughts	Self-harm (cutting,	Chronic illness
Thoughts of suicide	burning, etc.)	Other
Suicide attempt	Learning problems	

If other, please describe: _____

Please include any other information that you would like me to know about your child on the back of this sheet.