

North East Counseling and Trauma Services

Client Information, Page 1 of 2

Please Print Clearly

THIS SHEET MUST BE FILLED IN COMPLETELY

Readmit: __Yes __No

Client Data

Date _____ Client's Social Security # _____

Client's First Name _____ Last Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____

Birthdate ____/____/____ Age _____ Gender __F__M Race _____

Name of Spouse/Guardian _____ Phone _____

Address _____ City _____ State _____ Zip _____

Person Responsible for Payment _____ Soc. Sec. # _____

Signature of Person Responsible for Payment **X** _____ (Must be signed for services to begin)

Emergency Information

In case of emergency, contact:

Name (1) _____ Relationship _____ Phone _____ Work _____

Address _____ City _____ State _____ Zip _____

Name (2) _____ Relationship _____ Phone _____ Work _____

Address _____ City _____ State _____ Zip _____

Referral Source

How did you hear of our clinic (or from whom)? _____

Address _____ City _____ State _____ Zip _____

Phone _____ Relationship to referral source _____

Client Information Continued, Page 2 of 2

Medical

Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

Psychiatrist _____ Phone _____

Address _____ City _____ State _____ Zip _____

Other Physicians _____ Phone _____

Current Medications _____

Allergies _____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place _____ Phone _____ Hrs _____

Spouse: Place _____ Phone _____ Hrs _____

Insurance Information

Primary Insurance _____

Phone _____

Contract/ID# _____

Group/Acct# _____

Subscriber _____

Subscriber Date of Birth _____

Client's relationship to Subscriber

Self Spouse Child Other _____

Secondary Insurance _____

Phone _____

Contract/ID# _____

Group/Acct# _____

Subscriber _____

Subscriber Date of Birth _____

Client's relationship to Subscriber

Self Spouse Child Other _____

North East Counseling and Trauma Services

Personal History—Children and Adolescents

Client's name: _____ Date: _____

Gender: ___ F ___ M Date of birth: _____ Age: _____ Grade in school: _____

Form completed by (if someone other than client): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (home): _____ (work): _____ Ext: _____

If you need any more space for any of the following questions please use the back of the sheet.

Primary reason(s) for seeking services:

___ Anger management ___ Anxiety ___ Coping ___ Depression
___ Eating disorder ___ Fear/phobias ___ Mental confusion ___ Sexual concerns
___ Sleeping problems ___ Addictive behaviors ___ Alcohol/drugs ___ Hyperactivity
___ Other mental health concerns (specify): _____

Family History

Parents

With whom does the child live at this time? _____

Are parent's divorced or separated? _____

If Yes, who has legal custody? _____

Were the child's parents ever married? ___ Yes ___ No

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling? ___ Yes ___ No

If Yes, describe: _____

Client's Mother

Name: _____ Age: _____ Occupation: _____ ___ FT ___ PT

Where employed: _____ Work phone: _____

Mother's education: _____

Is the child currently living with mother? ___ Yes ___ No

___ Natural parent ___ Step-parent ___ Adoptive parent ___ Foster home

___ Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the mother?

___ Yes ___ No

If Yes, please explain: _____

How is the child disciplined by the mother? _____

For what reasons is the child disciplined by the mother? _____

Address: 57 North Street, Suite 217, Danbury, CT. 06810

Tel: (860) 841-6574 • Fax: (860) 606-9539

Client's Father

Name: _____ Age: _____ Occupation: _____ FT _____ PT

Where employed: _____ Work phone: _____

Father's education: _____

Is the child currently living with father? Yes No

Natural parent Step-parent Adoptive parent Foster home

Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the father?

Yes No

If Yes, please explain: _____

How is the child disciplined by the father? _____

For what reasons is the child disciplined by the father? _____

Client's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender	Lives	Quality of relationship with the client		
				home	away	
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	_____	_____	_____
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	_____	_____	_____
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	_____	_____	_____
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	_____	_____	_____

Others living in the household Relationship (e.g., cousin, foster child)

_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	_____	_____	_____
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	_____	_____	_____
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	_____	_____	_____
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	_____	_____	_____

Comments: _____

Family Health History

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Deafness | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glandular problems | <input type="checkbox"/> Perceptual motor disorder |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Heart diseases | <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Spinal Bifida |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Cleft lips | <input type="checkbox"/> Migraines | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Cleft palate | <input type="checkbox"/> Multiple sclerosis | _____ |

Comments re: Family Health: _____

Childhood/Adolescent History

Pregnancy/Birth

Child number ___ of ___ total children.

Has the child's mother had any occurrences of miscarriages or stillborns? _____ Yes _____ No

If Yes, describe: _____

Was the pregnancy with child planned? _____ Yes _____ No

Length of pregnancy: _____ Mother's age at child's birth: _____ Father's age at child's birth: _____

How many pounds did the mother gain during the pregnancy? _____

While pregnant did the mother smoke? _____ Yes _____ No If Yes, what amount: _____

Did the mother use drugs of alcohol? _____ Yes _____ No If Yes, type/amount: _____

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication)

_____ Yes _____ No

If Yes, describe: _____

Length of labor: _____ Induced: _____ Yes _____ No Caesarean? _____ Yes _____ No

Baby's birth weight: _____ Baby's birth length: _____

Describe any physical or emotional complications with the delivery: _____

Describe any complications for the mother or the baby after the birth: _____

Length of hospitalization: Mother: _____ Baby: _____

Infancy/Toddlerhood Check all which apply:

____ Breast fed ____ Milk allergies ____ Vomiting ____ Diarrhea
____ Bottle fed ____ Rashes ____ Colic ____ Constipation
____ Not cuddly ____ Cried often ____ Rarely cried ____ Overactive
____ Resisted solid food ____ Trouble sleeping ____ Irritable when awakened ____ Lethargic

Developmental History Please note the age at which the following behaviors took place:

Sat alone: _____ Dressed self: _____

Took 1st steps: _____ Tied shoelaces: _____

Spoke words: _____ Rode two-wheeled bike: _____

Spoke sentences: _____ Toilet trained: _____

Weaned: _____ Dry during day: _____

Fed self: _____ Dry during night: _____

Compared with others in the family, child's development was: _____ slow _____ average _____ fast

Age for following developments (fill in where applicable)

Began puberty: _____ Menstruation: _____

Voice change: _____ Convulsions: _____

Breast development: _____ Injuries or hospitalization: _____

Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)

Education

Current school: _____ School phone number: _____

Type of school: Public Private Home schooled

Other (specify): _____

Grade: _____ Teacher: _____ School Counselor: _____

In special education? Yes No

If Yes, describe: _____

In gifted program? Yes No

If Yes, describe: _____

Has child ever been held back in school? Yes No

If Yes, describe: _____

Which subjects does the child enjoy in school? _____

Which subjects does the child dislike in school? _____

What grades does the child usually receive in school? _____

Have there been any recent changes in the child's grades? Yes No

If Yes, describe: _____

Has the child been tested psychologically? Yes No

If Yes, describe: _____

Check the descriptions which specifically relate to your child.

Feelings about School Work:

Anxious Passive Enthusiastic Fearful

Eager No expression Bored Rebellious

Other (describe): _____

Approach to School Work:

Organized Industrious Responsible Interested

Self-directed No initiative Refuses Does only what is expected

Sloppy Disorganized Cooperative Doesn't complete assignments

Other (describe): _____

Performance in School (Parent's Opinion):

Satisfactory Underachiever Overachiever

Other (describe): _____

Child's Peer Relationships:

Spontaneous Follower Leader Difficulty making friends

Makes friends easily Long-time friends Shares easily

Other (describe): _____

Who handles responsibility for your child in the following areas?

School: Mother Father Shared _____ Other (specify): _____

Health: Mother Father Shared _____ Other (specify): _____

Problem behavior: Mother Father Shared _____ Other (specify): _____

If the child is involved in a vocational program or works a job, please fill in the following:

What is the child's attitude toward work? _____ Poor _____ Average _____ Good _____ Excellent

Current employer: _____ Position: _____ Hours per week: _____

How have the child's grades in school been affected since working? _____ Lower _____ Same _____ Higher

How many previous jobs or placements has the child had? _____

Usual length of employment: _____ Usual reason for leaving: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Physical Health

- | | | |
|--|---|---|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Hayfever | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hives | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Influenza | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Lead poisoning | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Congenital problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Severe colds |
| <input type="checkbox"/> Croup | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Severe head injury |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Thyroid disorders |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mumps | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Ear aches | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Wearing glasses |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Other skin rashes | <input type="checkbox"/> Other |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Paralysis | _____ |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Pleurisy | _____ |

List any current health concerns: _____

List any recent health or physical changes: _____

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten			
Breakfast	___ / week	_____	___ No	___ Low	___ Med	___ High
Lunch	___ / week	_____	___ No	___ Low	___ Med	___ High
Dinner	___ / week	_____	___ No	___ Low	___ Med	___ High
Snacks	___ / week	_____	___ No	___ Low	___ Med	___ High
Comments: _____						

Most recent examinations

Type of examination	Date of most recent visit	Results
Physical examination	_____	_____
Dental examination	_____	_____
Vision examination	_____	_____
Hearing examination	_____	_____

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter medications & supplements	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs? ___ Yes ___ No

If Yes, describe: _____

Counseling/Prior Treatment History

	Yes	No	When	Where	Reaction or overall experience
Counseling/Psychiatric treatment	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	___	_____	_____	_____
Drug/alcohol treatment	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____

Behavioral/Emotional

Please check any of the following that are typical for your child:

- | | | |
|---|---|---|
| <input type="checkbox"/> Affectionate | <input type="checkbox"/> Frustrated easily | <input type="checkbox"/> Sad |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Gambling | <input type="checkbox"/> Selfish |
| <input type="checkbox"/> Alcohol problems | <input type="checkbox"/> Generous | <input type="checkbox"/> Separation anxiety |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sets fires |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Head banging | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Attachment to dolls | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Sexual acting out |
| <input type="checkbox"/> Avoids adults | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Shares |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Hurts animals | <input type="checkbox"/> Sick often |
| <input type="checkbox"/> Blinking, jerking | <input type="checkbox"/> Imaginary friends | <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> Bizarre behavior | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Shy, timid |
| <input type="checkbox"/> Bullies, threatens | <input type="checkbox"/> Irritable | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Careless, reckless | <input type="checkbox"/> Lazy | <input type="checkbox"/> Slow moving |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Learning problems | <input type="checkbox"/> Soiling |
| <input type="checkbox"/> Clumsy | <input type="checkbox"/> Lies frequently | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Confident | <input type="checkbox"/> Listens to reason | <input type="checkbox"/> Steals |
| <input type="checkbox"/> Cooperative | <input type="checkbox"/> Loner | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Cyber addiction | <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Suicidal threats |
| <input type="checkbox"/> Defiant | <input type="checkbox"/> Messy | <input type="checkbox"/> Suicidal attempts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Moody | <input type="checkbox"/> Talks back |
| <input type="checkbox"/> Destructive | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Difficulty speaking | <input type="checkbox"/> Obedient | <input type="checkbox"/> Thumb sucking |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Often sick | <input type="checkbox"/> Tics or twitching |
| <input type="checkbox"/> Drugs dependence | <input type="checkbox"/> Oppositional | <input type="checkbox"/> Unsafe behaviors |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Over active | <input type="checkbox"/> Unusual thinking |
| <input type="checkbox"/> Enthusiastic | <input type="checkbox"/> Overweight | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Excessive masturbation | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Expects failure | <input type="checkbox"/> Phobias | <input type="checkbox"/> Worries excessively |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Psychiatric problems | _____ |
| <input type="checkbox"/> Frequent injuries | <input type="checkbox"/> Quarrels | _____ |

Please describe any of the above (or other) concerns: _____

How are problem behaviors generally handled? _____

What are the family's favorite activities? _____

What does the child/adolescent do with unstructured time? _____

Has the child/adolescent experienced death? (friends, family pets, other) ____ Yes ____ No

At what age? _____

If Yes, describe the child's/adolescent's reaction: _____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)

____ Yes _____ No

If Yes, describe: _____

Any additional information that you believe would assist us in understanding your child/adolescent?

Any additional information that would assist us in understanding current concerns or problems?

What are your goals for the child's therapy? _____

What family involvement would you like to see in the therapy? _____

Do you believe the child is suicidal at this time? ____ Yes ____ No

If Yes, explain: _____
