Nichols Counseling
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Child Client Information Form

Today's date: ______________________________ **Client #**_________________________
Note: If you have been a patient here before, please fill in only the information that has changed.

A. Identification
Your child's name: _______________________Date of birth: _____________ Age: ________ Grade: _______
Nicknames or aliases: _______________________________ Social Security #: ___________________________
Home street address: ____ Apt.:_______________
City: ____ State: ______________Zip: _____________________
Home/evening phone: ________________ Calls will be discreet, but please indicate any restrictions:___________
____

B. Referral: Who referred you to my office?
Name: ____ Phone: _________________________________
Address: ____
____
May I have your permission to thank this person for the referral? • Yes • No
How did this person explain how I might be of help to you? ____
____
____

C. Your child's medical care: From whom or where does your child get his/her medical care?
Clinic/doctor's name: ____ Phone: ________________________
Address: ____
If your child enters treatment with me for therapy, may I tell his/her medical doctor so that he/she can be fully informed and we can coordinate your child's treatment? • Yes • No
In the event of an emergency, may I contact your child's medical doctor and disclose necessary information so that he/ she can be fully informed and we can coordinate your child's treatment? • Yes • No

D. Parents' Marital Status
Are the child's parents: Married ____________ Divorced ____________ Never Married____________

If the parents are divorced, give the month and year the divorce was granted________________________________
Are both parents named as Joint Managing Conservators in the Divorce Decree? ______Yes ______No
Does either parent have primary physical custody of the child? ______Yes ______No
With whom does the child currently live?____
Is either parent remarried? If so, please explain.____
____
Have either parent's parental rights been terminated by a court? ______Yes ______No
Have either parent's rights to consent to treatment or obtain records of treatment been limited or restricted by a Court Order? ______Yes ______No If the answer is "Yes," please explain:__________________________
____
____

NOTE: A COPY OF THE PARENTS' DIVORCE DECREE OR APPLICABLE COURT ORDER MUST BE PROVIDED BEFORE ANY SESSIONS WITH THE CHILD WILL BE SCHEDULED.

E. Family Members (list those living in home with your child):

Name	Age	Sex	Grade	Relationship to child

F. **Medications:**

Name of Medication? Dosage/Mg? Frequency?

____
____
____
____

G. Any problems or concerns about your child's medications?___ Yes _____ No
(If yes have you talked to the prescribing physician? ____

H. Emergency Contacts:
List the name(s) of the person(s) who may be contacted by this office in the event of an emergency involving your child. Please be aware that the person(s) listed may receive information in an emergency situation that would otherwise be confidential by law. By listing the name(s) below, you give this office permission to contact the person(s) listed and provide necessary information about your child in the event of an emergency.

____
____
____

I. Chief Concern(s): Please describe the main difficulty that has brought your child to see me:

____
____
____

J. Has your child ever received counseling services before? __No __Yes. If yes,
When? With Whom? For What? With What results?

____
____
____

K. Abuse History? ___My child was not abused in any way. ___My child was abused (sexual, physical, emotional, neglect) If your child were abused:
Age of Abuse Who did it? Whom did you tell? Consequences of telling?

____
____
____

L. Child Developmental History:

1. Pregnancy and delivery: ____normal ___caesarian ____breech ___ premature ___other complications 2. The first few years of life: Breast-fed?__________ If so, for how long?____ Any allergies? ___________
Sleep patterns or medical problems: ____
3. Milestones: At what age did this child do each of these?
Sat without support: ______________________________________ Crawled:______________________
Walked without holding on: _________________________ Helped when being dressed: _______________
Ate with a fork:__________________________________ Stayed dry all day:________________________
Didn't soil his/her pants: __________________________________ Stayed dry all night: ________________
Dressed self completely: ____________________________________
4. Speech/language development
Age when child said first word understandable to strangers: _______________________________________
Age when child said first sentence understandable to a stranger: __________________________________
Any speech, hearing, or language difficulties? ____
____
____

M. Health
List all childhood illnesses, hospitalizations, medications, allergies, head trauma, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.
Condition Age Treated by whom? Consequences?

______________________________ _____ ___________________________________ __________________
______________________________ _____ ___________________________________ __________________
______________________________ _____ ___________________________________ __________________

N. Residences Outside your home**?** (Examples would be Foster Care, Residential Placement, etc) ____ **No** ___**Yes** (If yes please complete below):

From	To	Location	Reason for moving	With whom	Any problems?
_______	_______	_____________________	__________________	______________	______________
_______	_______	_____________________	__________________	______________	______________
_______	_______	_____________________	__________________	______________	______________

O. Schools

School (Name, district, address, phone)	Grade	Age	Teacher
____	_________	_________	___________________
____	_________	_________	___________________
____	_________	_________	___________________

Any concerns about progress in school? ___ Yes ___ No If yes, please list :__________________________
____
____

____

(**Office Use Only**) Insurance Information:
Name of Insurance Company: ___________________________________ Effective date of coverage: ______
Policy ID #:_____________________ Group #:______________ SSN#:___________________________
Policy Holder Name: ___________________________________ Date of Birth of Policy Holder ____________
Policy Holder Employer:_______________________________ Phone Number: ________________________
Authorization/Certificate #______________________________ Beg and End Dates: ______________________
Of Authorized Visits: _____ **Benefits**: Deductible: ________ Co Pay: _______ #Visits per year: __________