CHILD INFORMATION FORM

Child's Full Name:	Child's Date of Birth:	Your Full Name:	Today's Date:

FAMILY HISTORY:

Mother's Full Name:	Mother's DOB:	
Father's Full Name:	Father's DOB:	
Siblings : List below all siblings of the child listed above (Use back of page for additional siblings)	Siblings' DOB	Are mother and father listed above the biological parents of this child? If not, list name of parents

PREGNANCY & CHILDBIRTH HISTORY:

Please check box at left for any of the following that apply to child named above.

	Trauma to mother		Premature or early birth
	Injury to mother		Late birth
	Bleeding/spotting		Caesarean birth
	High or low blood pressure		Breech
	Toxemia		Forceps
	Gestational diabetes		Other complications of labor/delivery
	Mental health condition in mother		Jaundice
	Other Illnesses in mother		Injury
	Alcohol use by mother		Birth Defects
	Smoking by mother		Colic
	Drug use by mother		Illness
	Other relevant pregnancy history		Difficulty Feeding

DEVELOPMENTAL HISTORY:

Please check box at left for any of the following that apply to child named above.

	Cried Often		Sensitive
	Serious		Unusual reaction to immunizations
	Very Active		Difficulty gaining weight
	Very Inactive		Delay in reaching expected milestones
	Cuddly		Other:

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SIGNIFICANT ILLNESS AND/OR INJURY HISTORY:

Please list below any significant illnesses or injuries. Details should include ER visits, hospitalizations, treatments, disability, and current impact. Use additional paper if necessary.

Date	Condition	Details

CURRENT MEDICATIONS:

Medication	Dose	Doctor	Condition Treated	Date Started

MEDICAL PROVIDERS:

Pediatrician:____ Phone:________________________

Date of last visit:__________________ Reason for visit:____

Specialty Doctor:____Phone:________________

Date of last visit:__________________ Reason for visit:____

Counselor:____ Phone:_________________________

Date of last visit:__________________ Reason for visit:____

Other:____ Phone:_____________________________

Date of last visit:__________________ Reason for visit:____

SPECIAL CONCERNS:

Reports of Child Abuse/Neglect

Reported by:_______________________________ Date:_______________________________

CHILD INFORMATION FORM

Child's Full Name:	Child's Date of Birth:	Your Full Name:	Today's Date:

Agency Reported To:________________________ Investigator:________________________

Nature and outcome of report:

Legal/Police Involvement Related to Children:

Charges:____________________________________ Date:__________________________

Police Dept. Involved:_________________________________ Officer:______________________

Nature and outcome of case:

EDUCATION HISTORY:

Please list current grade first, followed by prior 3 years.

Grade	Teacher	School	Phone #

CHILD INFORMATION FORM

Child's Full Name:	Child's Date of Birth:	Your Full Name:	Today's Date:

Areas of academic special need or concern:

CHILDCARE:

Provider/School Name:_____________________________________ Teacher:_____________________

Address:____Dates attended:________________________

Days/Hours Spent with above provider: ____

Provider/School Name:_____________________________________ Teacher:_____________________

RELIGIOUS AFFILIATION:

Church Attended:___________________________________ Religion:____________________________

EXTRA-CURRICULAR ACTIVITIES:

Activity	Name of Instructor/Coach	Telephone #	Dates/Times of Activity

Other special interests, hobbies, talents of child:

Activities you and this child enjoy together:

CHILD INFORMATION FORM

Child's Full Name:	Child's Date of Birth:	Your Full Name:	Today's Date:

Activities this child enjoys with other parent:

Rules related to cell phone use, video games, movies and TV at your house:

What are the current custody and parenting time arrangements for this child?

How does this child act before and after parenting time with the other parent? Why is that?

What does this child enjoy most when he or she is with you?

Does this child enjoy parenting time with the other parent?

How do you encourage this child to share love, affection and contact with the other parent?

What has the impact of parental separation and related court proceedings been on this child?

Are there any particular people such as siblings or relatives to whom this child is particularly close?

CHILD INFORMATION FORM

Child's Full Name:	Child's Date of Birth:	Your Full Name:	Today's Date:

CURRENT BEHAVIORAL, HEALTH OR OTHER CONCERNS:

Please check box at left for any of the following that apply to child.

	Headaches, dizziness		Feels sad or unhappy
	Eating or nutrition concerns		Feels lonely
	Wetting, soiling		Inferiority feelings
	Sleeping difficulties		Thinks or talks about hurting self
	Lying, disobeying		Suicidal behaviors/threats
	Stealing, harming others		Hyperactivity, can't sit still
	Aggressive to people or animals		Inattention, poor focus
	Destructive to property		School difficulties
	Fire Setting		School refusal or anxiety
	Easily frustrated, anger problems		Sexualized behavior
	Cries easily		Seems out of touch with reality
	Feels bad about self		Has few or no friends
	Worries, has anxiety, feels panicky		Shy or withdrawn
	Difficulty making decisions		Dependent or needy

Is there anything else that I should know about the child?

By signing below I certify that I have used my best efforts to gather all information, and that the information I have provided is true, accurate and complete.

Date:_______________________

Signature of person completing form:____