SHEFFER
PSYCHOLOGICAL SERVICES

120 W Eastman St., Suite 305, Arlington Heights, IL 60004-5950

Child Information Form

Today's date: ___/___/___

Note: If your child has been a patient here before, please fill in only the information that has changed.

A. Identification

Child's full name: _____ Date of birth: ___/___/___

Nicknames: _____

Child's legal guardian: _____ Person(s) completing this form: _____

Disability status: _____ ❑ Talk about later

Gender identity: _____ ❑ Talk about later

Sexual orientation: _____ ❑ Talk about later

Racial/ethnic identities: _____ ❑ Talk about later

Religious/spiritual traditions or identity: _____ ❑ Talk about later

Other ways you identify your child and consider important: _____

B. Family information

Mother/guardian: _____ Age: ____

Best phone number: _____ Other phone number: _____

Address: _____

Email: _____ Occupation: _____

Employer: _____ Location: _____

Father/guardian: _____ Age: ____

Best phone number: _____ Other phone number: _____

Address: _____

Email: _____ Occupation: _____

Employer: _____ Location: _____

Parents are currently: ❑ Married ❑ Divorced ❑ Separated ❑ Remarried to others ❑ Never married
❑ Other: _____

Patient lives with: ❑ Mother ❑ Father ❑ Relative ❑ Guardian ❑ Other: _____

Who has legal custody* of this child? ❑ Mother ❑ Father ❑ Both/either/shared ❑ Relative
❑ Guardian ❑ Other: _____

*Please bring custody or court papers to the first appointment if they exist.

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Members of the household and other important persons in the child's life:

Name	Relationship	Age	Sex	Health, behavioral or learning difficulties?	Last grade in school completed, or works as a . . .	How does this person get along with the child?

C. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call? Name: _____ Phone: _____

Relationship: _____ Address: _____

D. Referral

Who gave you my name to call? Name: _____ Phone: _____

Address: _____

How did this person explain how I might be of help to you? _____

Is this person's relationship with you ❑ personal or ❑ professional?

If professional, may I have your permission to thank this person for the referral? ❑ Yes ❑ No

Should I consult with this person about the referral? ❑ Yes ❑ No

E. Current problems or difficulties

Please describe the main difficulties that led to your bringing this child to see me: _____

_____

When did these problems start? _____

What makes these problems worse? _____

_____

What makes these problems better? _____

_____

With therapy, how long do you think it will take for these to get a lot better? _____

F. Development

1. Pregnancy and delivery

Prenatal medical illnesses or problems: _____

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Maternal substance use: ❑ Alcohol ❑ Tobacco ❑ Medications ❑ Other drugs

Maternal stressors: _____

Was the child premature? ❑ No ❑ Yes, by ____ weeks. Birth weight: ____ Birth length: ____

Birth complications or problems? _____

2. The first few months of life

Breast-fed? ❑ No ❑ If yes, for how long? _____ Feeding problems? _____

Allergies? _____ Sleep patterns or problems: _____

Relationship with mother: _____

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 or her pants during day: _____ Stayed dry all night: _____ Tied shoelaces: _____ Buttoned buttons: _____ Slept alone: _____ Rode bicycle: _____

4. Speech/language development

Age when child said first word understandable by a stranger: _____ Said first sentence understandable to a stranger:

Any current speech, hearing, or language difficulties? _____

5. Any other current concerns about development? _____

_____

G. Homes/residences

If the child was ever placed out of a home, see item 10 under section I, below.

Child's age when moved	Location	Lived with whom?	Reason for moving	Problems there

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H. Education

How many years of schooling has your child had (including preschool and kindergarten)? ____ years.

From (date)	To (date)	School's name and district	Teacher	Special classes or supports?	Did your child graduate?

May I call and discuss your child with the current teacher? ❑ No ❑ Yes If yes, phone number: _____

I. Health and medical care

1. How is your child's general level of health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor
2. Pediatrician/PCP/Clinic/doctor's name: _____

   Phone: _____ Address: _____

   - If your child enters treatment with me for psychological problems, may I tell your child's medical doctor/PCP, so that he or she can be fully informed and we can coordinate your child's treatment? ❑ Yes ❑ No
   - If your child sees other doctors or clinics, please check here ❑ and write their names, addresses, and phone numbers on the back of this page.
3. List all childhood illnesses, hospitalizations, medications, allergies, important injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age, or from-and-to ages	Treated by whom? Mark the primary care provider (PCP) with a star.	Effects/outcome

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4. List *all* medications, drugs, or other substances your child has taken in the last year—prescribed medications, over-the-counter vitamins, supplements, herbs, and others.

Medication	Dosage? And how often?	For what condition?	When started?	Effects/outcome	Prescribed and supervised by whom?

5. Describe your child's allergies to medications or anything else.

Allergic to	Allergic reaction	Treatment and medications

6. Has your child ever received inpatient or outpatient psychological, psychiatric, drug or alcohol treatment, medications or counseling services before? ❑ No ❑ Yes. If yes, please indicate:

For what (diagnoses)?	From (date)	To (date)	Name of doctor, provider, or agency and location	What kind of treatment?	With what results?

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For what (diagnoses)?	From (date)	To (date)	Name of doctor, provider, or agency and location	What kind of treatment?	With what results?

7. Has any other family member been hospitalized for a psychiatric, emotional, or substance use disorder?
   ❑ No ❑ Yes. If yes, please indicate:

Name of family member	For what (diagnoses)?	What kind of treatment?	From (date)	To (date)	With what results?

8. Describe any substance abuse or mental illness in family members (who, relationship, disorder, currently active?): ___

9. Has the child had any residential placements, institutional placements, or foster care? ❑ No ❑ Yes. If yes, please indicate:

Age entered	Age left	Program's name	Reason for placement	Problems there

10. Other important family issues (losses, adoption, stepparents, other relatives): _____

J. Abuse history

Note: If I suspect that there is or has been abuse, I have to report that. Please be aware of this as you answer the questions below, or leave them blank.

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❑ This child was not abused in any way. ❑ This child may have been abused.

❑ This child was abused. For the kind of abuse, use these letters: P = Physical, such as beatings; S = Sexual, such as touching/molesting, fondling, or intercourse; N = Neglect, such as failure to feed, shelter, or protect; E = Emotional, such as humiliation, etc.

Child's age	Kind of abuse	By whom? Intimate partner? Relative? Sibling? Other (specify)?	Effects on the child?	Whom did the child tell?	What happened then?

K. Chemical use by your child

1a. How many caffeine drinks are consumed by your child each day (coffee, tea, colas, energy drinks, etc.)?

1b. How often each week are medications (prescription or over the counter) or energy drinks or other chemicals used for alertness? _____

2. How much tobacco is smoked or chewed each week? Kind: _____ Amount _____

3. How many drinks of beer, wine, or liquor are consumed by your child in a typical week? ____

4. Did he or she ever drink to unconsciousness, or run out of money because of drinking? ❑ No ❑ Yes

5. Has your child ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner? ❑ No ❑ Yes. If yes, which and when? _____

6. Which drugs (not medications prescribed for the child) have been used in the last 5 years? _____

_____

7. Do you think that your child has a drug or alcohol problem? ❑ No ❑ Yes. If yes, what kind? _____

_____

L. Legal history

1. Are you or your child presently being sued, suing anyone, or thinking of suing anyone? ❑ No ❑ Yes. If yes, please explain: _____

2. Is your reason for bringing the child to see me related to an accident or injury? ❑ No ❑ Yes. If yes, please explain:

3. Are you or your child required by a court, the police, or a probation/parole officer to have this appointment?
   ❑ No ❑ Yes. If yes, please explain: _____

4. List any contacts with the police, courts, and jails/prisons that ❑ you have had, or ❑ your child has had. Include all open charges and pending ones. Under "Jurisdiction," write in a letter: F = Federal, S = State, CO = County, CI = City. Under "Outcome," write in the *time* and the *type* of sentence you or the child served or must serve: CD = Charges Dropped, AR = Accelerated Release or Alternative Resolution, CS = Community Service, F = Fine, I = Incarceration (jail or prison), PR = PRobation, P = Parole, R = Restitution, O = Other.

Date	Charge/arrest	Jurisdiction	Outcome	Probation/parole officer's name	Attorney's name

5. Your current attorney's name: _____ Phone: _____
6. Are there any other legal involvements? ❑ No ❑ Yes. If yes, please explain: _____

M. Special skills or talents of the child

List hobbies, readings, sports, recreational, musical, TV, and toy preferences, etc.: _____

N. Friends of the child

How many? ____ Their gender: ❑ Only same ❑ Both ❑ Only other

Their ages: ❑ About the same as my child ❑ Mostly older ❑ Mostly younger

Activities with friends: _____

Influence of friends on child: ❑ Positive ❑ Negative. Specifics: _____

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O. Other

Is there anything else that is important for me as your child's therapist to know about, and that you have not written about on any of these forms? ❑ Yes, and I have written about it on the back of this page or another sheet of paper.

Please do not write below this line.

P. Follow-up by clinician

Based on the responses above and on ❑ interview data ❑ records I reviewed ❑ other information: _____ _____, I have requested the client's parent/guardian to complete and/or I have completed the following forms: ❑ Chemical use ❑ Risk assessment ❑ MSE ❑ Other: _____

I affirm that all of the information provided above is true and complete. I agree to promptly advise my provider if any of the above information changes.

_____ _____ ____/____/____

Client's parent/guardian's signature Printed name Date

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

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