Snohomish Child and Family Therapy
1728 W Marine View Dr
Everett, WA 98201-2094

CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _____

Your child's name: _____
Last First Middle Initial

Parent or Legal Guardian's Name: _____
Last First Middle Initial

Child's date of birth: _____ **Gender:** _____

Parent or Legal Guardian's Social Security #: _____

Home street address: _____

City: _____ **State:** _____ **Zip:**_____

Parent or Legal Guardian's Name of Employer: _____

Address of Employer: _____

City: _____ **State:** _____ **Zip:**_____

Home Phone: _____ **Work Phone:** _____
Cell Phone: _____ **Email:** _____

Calls will be discreet, but please indicate any restrictions:_____

_____

Referred by: _____

- May I have your permission to thank this person for the referral?
  ☐ Yes ☐ No
- If referred by another clinician, would you like for us to communicate with one another?
  ☐ Yes ☐ No

Person(s) to notify in case of any emergency: _____ _____
Name Phone

We will only contact this person if we believe it is a life or death emergency. Please provide your signature to indicate that we may do so: (Your Signature):_____

Please briefly describe your child's presenting concern(s):_____

_____

_____

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

_____

_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)?_____

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses your child has had:_____

_____

_____

_____

Current Medications (if you need more room, please write on the back of this page):

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous medical hospitalizations (Approximate dates and reasons): _____

_____

_____

Previous psychiatric hospitalizations (Approximate dates and reasons): _____

_____

Has your child ever talked with a psychiatrist, psychologist, or other mental health professional? (If yes, please list approximate dates and reasons): _____

_____

_____

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual
__Transgender __ Asexual __In Question __Other: _____

Racial/Ethnic Identity:

__African/African-American/Black
__American Indian/Alaska Native
__Asian/Asian-American/Asian Pacific Islander
__Bi-Racial/Multi-Racial
__ Latino/Latino-American
__ Middle Eastern/Middle Eastern-American
__White/European-American
__Not listed

FAMILY:

How would you describe your child's relationship with his or her mother?_____

_____

_____

How would you describe your child's relationship with his or her father?_____

_____

_____

Are the child's parents still married or did they divorce?_____ If they divorced, how old was the child when the parents separated or divorced and how do you think this impacted him or her? _____

_____

Please describe your child's relationship with his or her grandparents: _____
_____
_____

Were there any other primary care givers who have had a significant relationship with your child? If so, please describe how these people may have impacted your child's life: _____
_____
_____

How many sisters does your child have? _____ Ages? _____

How many brothers does your child have? _____ Ages? _____

How would you describe your child's relationships with his or her siblings?_____
_____
_____
_____

SOCIAL SUPPORT, SELF-CARE, & EDUCATION:

POOR EXCELLENT

Child's current level of satisfaction with friends and social support: 1 2 3 4 5 6 7

How would you describe your child's relationships with his/her peers? _____
_____

Please briefly describe any history of abuse, neglect and/or trauma: _____
_____
_____

Please briefly describe your child's self-care and coping skills: _____
_____
_____

What are your child's diet, weight, and exercise/activity patterns?_____
_____
_____

Please briefly describe your child's school performance and experience:_____
_____
_____

What are your child's hobbies, talents, and strengths?_____
_____
_____

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD & ***CIRCLE*** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST

Anxiety →	Tantrums →	Nausea →
Depression	Parents Divorced	Stomach Aches
Mood Changes	Seizures	Fainting
Anger or Temper	Cries Easily	Dizziness
Panic	Problems with Friend(s)	Diarrhea
Fears	Problems in School	Shortness of Breath
Irritability	Fear of Strangers	Chest Pain
Concentration	Fighting with Siblings	Lump in the Throat
Headaches	Issues Re: Divorce	Sweating
Loss of Memory	Sexually Acting Out	Heart Problems
Excessive Worry	History of Child Abuse	Muscle Tension
Wetting the Bed	History of Sexual Abuse	Bruises Easily
Trusting Others	Domestic Violence	Allergies
Communicating with Others	Thoughts of Hurting Someone Else	Often Makes Careless Mistakes
Separation Anxiety	Hurting Self	Fidgets Frequently
Alcohol/Drugs	Thoughts of Suicide	Impulsive
Drinks Caffeine	Sleeping Too Much	Waiting His/Her Turn
Frequent Vomiting	Sleeping Too Little	Completing Tasks
Eating Problems	Getting to Sleep	Paying Attention
Severe Weight Gain	Waking Too Early	Easily Distracted by Noises
Severe Weight Loss	Nightmares	Hyperactivity
Head Injury	Sleeping Alone	Chills or Hot Flashes

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems		Physical Abuse		Depression	
Legal Trouble		Sexual Abuse		Anxiety	
Domestic Violence		Hyperactivity		Psychiatric Hospitalization	
Suicide		Learning Disabilities		"Nervous Breakdown"	

Any additional information you would like to include:

_____

_____

_____