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Child/Adolescent Therapy Enrollment Form

Today's Date: _____

Parent or Caregiver Information

Name: _____
Male ☐ Female☐ Transgender☐
Date of Birth: _____
Address: _____
City: _____
State: _____ Zip: _____
Home Phone: _____
Employer: _____
Job Title: _____
Work Phone: _____
Education: High School/Associates/Bachelors/Masters/Technical
Email address: _____

Name: _____
Male ☐ Female☐ Transgender☐
Date of Birth: _____
Address: _____
City: _____
State: _____ Zip: _____
Home Phone: _____
Employer: _____
Job Title: _____
Work Phone: _____
Education: High School/Associates/Bachelors/Masters/Technical
Email address: _____

Other Adults in the Home

Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____

Marriage History

Present marriage to _____ From: _____ To: _____
Previous marriage to _____ From: _____ To: _____

Child Information

Child's Legal Name: _____
Child's Birthday: _____ Grade: _____ School: _____

Doctor: _____ Phone Number: _____

Teacher: _____ Phone Number: _____

School Counselor: _____ Phone Number: _____

May I contact the school/doctor to gather information helpful to services if needed?

Yes ☐ No ☐ (*If YES, you will be asked to sign a consent form)*

Has your child been in counseling services before? Yes ☐ No ☐

If "yes", please provide name of counselor and dates: _____

_____

Prenatal History

Prenatal Care? _____

Full Term: Yes ☐ No ☐ If "no", what was the gestational age? _____

Birth Weight: _____

Complications with pregnancy or birth? _____

_____

Was the baby admitted in the NICU? Yes ☐ No ☐ If "yes", how long? _____

Was the baby: Breastfed ☐ or formula fed ☐?

Is the child vaccinated? Yes ☐ No ☐ Other _____

Developmental Milestones

Age when child: Walked _____ Talked _____ Toilet Trained _____

Problems in School?

Yes ☐ No ☐ If "yes", what type? _____

Is the child on an IEP? Yes ☐ No ☐ Why? _____

_____

Has the child repeated a grade? Yes ☐ No ☐ Which grade? _____

Why? _____

Nutrition

Please describe your child's typical daily diet including timing of meals/snacks:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Liquids: _____

Daily Routine

Please describe the child's typical daily routine.

_____

_____

_____

_____

Activities

Please describe your child's favorite activities, toys, etc.

_____

_____

_____

At Home

Where does the child sleep? _____ Does the child share a room? _____

With whom does the child share a room? _____ Age _____

Do you have a bedtime routine? Yes ☐ No ☐ If "yes", please describe _____

_____

Bed time problems? _____

Night time waking problems? _____

_____

Nightmares? Yes ☐ No ☐ Night Terrors? Yes ☐ No☐ Sleep walking/talking? Yes ☐ No ☐

If "yes", please give the child's age and a brief explanation _____

_____

Eating problems? Yes ☐ No ☐ If "yes", please give the child's age and a brief explanation _____

_____

Bathing problems? Yes ☐ No ☐ If "yes", please give the child's age and a brief explanation _____

_____

Allergies (food or other)? Yes ☐ No ☐ If "yes", please give the child's age and a brief explanation ___

Does the child listen to adults? Yes ☐ No ☐ Please give a brief explanation _____

Do you spank? Yes ☐ No ☐ If "yes", at what age did you begin and a brief explanation of how you spank _____

Do you use other types of discipline in your home? Yes☐ No ☐ If "yes", a brief explanation of the discipline used _____

Major Life Experiences

Medical History:

Currently under medical care?	Yes ☐	No ☐
Been hospitalized?	Yes ☐	No ☐
Required a medical procedure?	Yes ☐	No ☐
Failure to thrive?	Yes ☐	No ☐

If yes, please give the child's age and a brief explanation _____

Accidents:

Motor vehicle?	Yes ☐	No ☐
Natural disaster?	Yes ☐	No ☐
Fire?	Yes ☐	No ☐
Other?	Yes ☐	No ☐

If yes, please give the child's age and a brief explanation _____

Violence:

Witnessed domestic violence?	Yes ☐	No ☐
Witnessed sibling being physically abused?	Yes ☐	No ☐
Victim of physical abuse?	Yes ☐	No ☐
Other?	Yes ☐	No ☐

If yes, please give the child's age and a brief explanation _____

Sexual Abuse:

Witnessed sexual behavior?	Yes ☐	No ☐
Reported sexual abuse?	Yes ☐	No ☐
Participates in "sexual play with other children"	Yes ☐	No ☐
Sexualized behavior with adults?	Yes ☐	No ☐

Other? Yes ☐ No ☐
If yes, please give the child's age and a brief explanation _____

_____

Mental health problems in the family? Yes ☐ No ☐
If yes, who? _____

Give a brief explanation of the type of mental health problems _____

_____

Is your child currently taking medications?
Medication _____ Dosage _____ Medication _____ Dosage _____

Parents:

Mother: _____

Date of Birth: _____ Marital status: _____ Occupation: _____

Any history of childhood sexual abuse? Yes ☐ No ☐, if "yes" what age and a brief explanation of abuse _____

_____

History of substance abuse? Yes ☐ No ☐, if "yes", age begun and type of substances abused

_____

Other type of abuse _____

Father: _____

Date of Birth: _____ Marital status: _____ Occupation: _____

Any history of childhood sexual abuse? Yes ☐ No ☐, if "yes" what age and a brief explanation of abuse _____

_____

History of substance abuse? Yes ☐ No ☐, if "yes", age begun and type of substances abused

_____

Other type of abuse _____

Biological Siblings (use back of sheet if needed):

(1) Name _____ Age: _____
(2) Name _____ Age: _____
(3) Name _____ Age: _____

Other children in the home

Name _____ Birthdate _____ Age _____ Grade _____

Belief System

It is important to me to be respectful of each family's respective belief system. Please answer the following questions to help me understand yours. Thank you.

Did you participate in organized religion as a child? Please explain. _____

_____

Are you currently involved in an organized religious group? Which one? _____

_____

What is your child taught about what happens to people when they die? _____

_____

How does your belief system influence your parenting style? _____

_____

_____

What type of change do you hope to see in your family by participating in counseling? _____

_____

_____

What are your child's strengths? _____

_____

_____

_____

Is there anything else you would like me to know? _____

_____

_____

_____

_____

_____

_____

Thank you. Please bring this completed form to your assessment appointment.