Biographical Information Form – Child

To assist us in providing services to you, please complete this form as fully and openly as possible. All private information is held in the strictest confidence within legal limits. Some of the information is required by our accrediting and licensing agencies. **If you need help completing this form, please do not hesitate to ask.** Thank you for your cooperation.

Today's Date:_____ Birth Date:_____ Social Security #:_____

Referred by_____

Name:_____ Age:_____ Race/Ethnicity:_____

Gender: [ ] M [ ] F [ ] Transgender [ ] Non-binary [ ] Prefer not to respond

Preferred pronouns_____

Address: _____
County:_____ City:_____ State:_____ Zip:_____

Do you live in a [ ] House [ ] Apartment [ ] Mobile Home [ ] Other _____

Phone number_____ If we need to call you, may we leave a message? [ ] Yes [ ] No

What is the best number to text appointment reminders?_____

Who has legal custody of child? _____

If joint, has the other parent/guardian been informed (circle one)? [ ] YES [ ] NO

Who currently lives in child's household?

Name	Relationship	Age	Gender

Is CPS involved with your case? YES NO

If yes, CPS Worker's Name:_____ County:_____

What is/are the main reasons for this visit?_____

_____

_____

EDUATIONAL HISTORY

Child's grade in school:_____ Name of School:_____

Age that child started 1st grade:_____ Check all that apply: [ ] infant day care [ ] preschool [ ] kindergarten

Official school classification:

[ ] Learning disability [ ] Mental Retardation [ ] Other: _____

[ ] ADHD [ ] Visually Impaired _____

[ ] Behavioral Disorder [ ] Hearing Impaired _____

Type of placement: [ ] Regular classes [ ] Special education [ ] Honors [ ] Alternative school [ ] Home

What grades does the child usually receive?_____

Have grades changed recently? YES NO Details:_____

_____

MEDICAL HISTORY

Primary care physician:_____

Address: _____

Are you under the care of a psychiatrist: [ ] Yes [ ] No If so, whom:_____

Other important healthcare providers:_____

Generally speaking, how would you describe the child's overall physical health:

[ ] Excellent [ ] Average [ ] Below Average [ ] Poor

HOSPITALIZATIONS (PHYSICAL OR MENTAL HEALTH)

Hospital	Dates	Reason	Outcome

OUTPATIENT MENTAL HEALTH TREATMENT

Facility/Therapist	Dates	Reason	Outcome

MEDICATIONS

Medication	Dose	Reason	Prescribing Physician

Compliant with medication? [ ]Yes, [ ] No, If no, please explain_____

Allergies:_____

Other important medical information:_____

_____

_____

FAMILY HISTORY

Mother's Name:_____ Age:_____ Educational Level:_____

If mother is deceased, how old was child when she died?_____

Father's Name:_____ Age:_____ Educational Level:_____

If father is deceased, how old was child when he died?_____

Are the child's parents (check all that apply):

[ ] Married to each other [ ] Divorced Year:_____

[ ] Separated Year:_____ [ ] Re-married Year:_____

Please list biological or half-siblings and age(s):

_____

_____

History of Homelessness [ ] Yes [ ]No

ABUSE HISTORY

Has child been a victim of any type of abuse? [ ] Yes [ ] No

Has child ever abused anyone? [ ] Yes [ ] No

Has child ever been a victim of ANY other crime? [ ] Yes [ ] No

Is there a family history of:

Substance abuse [ ] Yes [ ] No Describe_____

Suicide [ ] Yes [ ] No Describe_____

Violence [ ] Yes [ ] No Describe_____

Psychiatric Problems [ ] Yes [ ] No Describe_____

Criminal Activity [ ] Yes [ ] No Describe_____

RELIGIOUS/SPIRITUAL CONCERNS

What is your religious preference?_____

How important is spirituality/religion in your life?

Not at all					Somewhat				Extremely
1	2	3	4	5	6	7	8	9	10

Do you have any concerns related to spirituality or religion?_____

_____

_____

Is there anything else you would like the counselor to know that has not already been covered?