Client Information

Date:

Child's Name:

Client relationship to the Child:

Family Physical Street Address:

Parent/Primary Guardian Name & Date of Birth:

Other Parent/Secondary Guardian Name & Date of Birth:

Parents are: Married Separated Divorced Never Married

Parent Occupations:

Mailing Address (if different):

Date of Birth of Child: Age: Gender:

Child's grade in school:

Phone: Home: Work: Cell:

Parent/Primary Guardian Email:

Other Parent/Secondary Guardian Email:

What is your preferred mode of communication (email, phone, or both)? Please specify which email address, phone number, etc.

Current Diagnosis (if applicable):

Current Insurance Company: _____ Please note, CLEAR does not take insurance, but it is required that we are aware of current insurance plan.

Language(s) spoken:

Client Lives with (please list members of household):

Emergency Contact:

Client Questionnaire

1. What concerns do you have for your child's well-being at this time?

2. When did you first start having concerns about your child's development, behavior, learning, or mental health?

3. Is the school aware of your concerns and what was the response?

4. Considering the following issues, which would you consider to be most relevant for your child? Please rate from 1-11 (1 being not at all concerned and 11 being very concerned)

    - Cognitive (Intelligence)
    - Learning (Academics)
    - Communicating (Language)
    - Socializing (Making friends & Social skills)
    - Daily Living (Adaptive skills & self-care)
    - Moving & Sensory (Motor coordination & sensory sensitivities)

- Focusing (Attention)
- Remembering (Memory)
- Organizing (Planning & Executive Functioning)
- Feeling (Emotions & Mood)
- Behaving (Following rules and listening)

5. What are your child's strengths?

6. What questions would you like answered during the evaluation or consultation?

7. Who referred you to CLEAR Child Psychology?

Family History

Is there any history of the following on either side of your child's family? Please indicate Y for yes and N for no. If yes, please indicate the child's relationship to that individual. *Ex. Y, Maternal Grandmother*

Depression:
Anxiety:
Bipolar:
Intellectual Disability:
Learning Disabilities:
Alcohol or drug abuse:
Attention Deficit Disorder:
Autism:
Developmental Delays:
Other relevant:

Please share any other family history concerns that may be an issue for your child:

Medical History

Now, consider your child's own medical history. Are any of these issues for your child, either currently or in the past? Please indicate Y or yes or N for no and indicate whether it is C for current or P for past.
Example: Y, C

Digestion problems:

Sleep problems:

Eating problems:

Frequent illnesses (colds, viruses):

Chronic illnesses (diseases, genetic conditions):

Ear infections:

Headaches:

Tics:

Urinary problems:

Bowel issues:

Toilet training problems:

Sensory sensitivities:

Extreme reactions to minor events:

8. List all medications that your child is currently taking.

9. Please list all of your child's current and previous mental health providers and any previous evaluations.

Mental Health History

Now, consider your child's own medical history. Are any of these issues for your child, either currently or in the past? Please indicate Y or yes or N for no and indicate whether it is C for current or P for past.
Example: Y, C

Aggressive behavior:
Excessive crying:
Tantrums:
Trauma:
Poor social skills:
Speech Problems:
Learning Problems:
Distractibility:
Learning Problems:
Distractibility:
Anxiety:
Panic attacks:
Mental Health hospitalization:
Frequent injuries:
Anger problems:
Unusual fears:
Suicidal thoughts:
Self-injury:

10. Any other concerns that you would like to mention?

Education

School History

Tell us about your child's school history. Did he or she attend daycare or preschool? List schools and note grades/dates attended.

11. Is your child on an Individualized Education Program, IFSP, 504 plan, or in the Response to Intervention program at school?

12. If so, please describe any services or accommodations your child receives.

13. Does your child attend any therapy or support programs in the community?

14. What else should we know to best help your child?

All done! Thank you for completing the client information form. Please save your responses and email to:

dr.harrison@clearchildpsychology.com

CLEAR