NICOLE PRAY CONSULTING LIMITED

CHILD INFORMATION FORM

Name of Child(ren): _____ Date: _____

Date of Birth: _____ Age: _____

Home Address: _____ Address Line 2: _____

Home Phone: _____ Cell _____

Child's School: _____

Name of Parent(s): _____

Date of Birth: _____ Age: _____

Home Address: _____ Email Address: _____

Home Phone: _____ Cell _____

Work Phone: _____ Employer: _____

May I call you and leave messages at home? Yes ☐ No ☐ On your cell? Yes ☐ No ☐ At Work? Yes ☐ No ☐

Marital status of parents: S ☐ M ☐ D ☐ W ☐ LT ☐ Married how long? _____ Previously Married? Yes ☐ No ☐

Siblings: _____ Date of Birth/Age _____ Step/Bio/Adopted _____

Date of Birth/Age _____ Step/Bio/Adopted _____

Date of Birth/Age _____ Step/Bio/Adopted _____

Date of Birth/Age _____ Step/Bio/Adopted _____

Date of Birth/Age _____ Step/Bio/Adopted _____

MEDICAL HISTORY

Is your child currently experiencing physical problems or medical problems (e.g. headaches, body aches, stomach problems)? Yes ☐ No ☐

If yes, please explain: _____

Previous hospitalizations for medical reasons Date: _____ Reason: _____

Date: _____ Reason: _____

Please list any learning disabilities: _____

COUNSELING AND PSYCHIATRIC HISTORY

Has your child had previous counseling? Yes ☐ No ☐ If yes, when? _____ Name and location of counselor: _____

If yes, for what reason? _____ For how long? _____

Has your child ever been diagnosed with or treated for any type of mental illness? Yes ☐ No ☐ If yes, what? _____

Has anyone in your family been diagnosed with or treated for any type of mental illness? Yes ☐ No ☐ If yes, what?

MEDICATION(S)	DOSAGE

REASONS FOR SEEKING HELP

What concerns have brought your child to counseling today? _____

What do you hope your child will gain from counseling? _____

EMERGENCY CONTACT (Next of Kin – Other than Spouse)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Address: _____ Email Address: _____

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