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CLIENT INFORMATION FORM – CHILD
Please use BLACK or BLUE ink

GENERAL INFORMATION

Today's Date _____

Child's Name _____ Referred by _____

Address/City/Zip _____ Home Phone () _____ Parent Cell () _____

Parent e-mail address: _____ Child e-mail address _____

Birthdate _____ Age _____ All who live with child _____

EMPLOYMENT (Parent/Guardian)

Parent/Guardian #1 Name _____ Relationship to child _____

Occupation _____ Employer _____ Work phone () _____

Parent/Guardian #2 Name _____ Relationship to child _____

Occupation _____ Employer _____ Work phone () _____

SCHOOL (Child)

Name of child's school _____ City _____ Phone () _____

Grade _____ School Counselor _____ Grades in current classes _____

Favorite Subjects _____ Least Favorite _____

Extracurricular Activities _____

PERSONAL / FAMILY INFORMATION

Parents' Marital Status _____ If divorced or not with parent, who has legal custody? _____

Physical custody? _____ What is visitation arrangement? _____

Names/ages of siblings (from this or other marriages) _____

Pets _____ Extended family who live nearby _____

Emergency Contact, if those in house cannot be reached:

Name _____ Relationship _____ Phone(s) () _____

Preferred Payment: _____ Credit Card (VISA, MC, Discover) \$140/session
_____ Zelle (to DrJ@DrJJaffe.com) \$135/session

Credit Card (Billing will appear as THERAPY PARTNER) (Upload card to client Portal on TherapyPartner.com)

I will need claim form for insurance reimbursement (in CA only) ___ YES ___ NO OVER

HEALTH HISTORY

Is child CURRENTLY seeing another psychotherapist or counselor? ____ If so: Phone () _____

Name _____ For how long? ____ For what purpose(s)? _____

Has child PREVIOUSLY been in psychotherapy or counseling? ____ If so: When? _____

For how long? ____ Family or child counseling? _____ Purpose(s)? _____

Outcome/Results? _____ Current concerns: _____

What prescription medications is child CURRENTLY taking? _____

What PREVIOUS medications has child taken for psychological or learning purposes? _____

Child's usual bedtime? ____ Wake up time? ____ Any sleep disturbances? _____

Child's food preferences / dislikes? _____ Any eating problems? _____

Pregnancy and Birth History: Full Term ____ Premature ____ Adopted ____

Any unusual circumstances or difficulties with the pregnancy or post-partum? _____

Date of last medical exam ____ Doctor's Name _____ Phone () _____

Physical or medical conditions: _____

Other useful information to assist in counseling: _____

EXAMPLES OF QUESTIONS FOR CHILD (to answer in early sessions)

What's your favorite TV show? Do you play video or computer games? If so, what's your favorite?

If you had \$1,000 and could spend it any way you wanted, what would you do with it?

How many places have you lived? Who took care of you when you were little? How many babysitters or nannies?

How do you get along with your siblings? How do you handle disagreements?

What do you do when you are mad? When you are scared? What is a scary thing that has happened in your life?

How do you know when your parents are upset with you? How do you know when they are upset with each other?

Did you ever have a serious accident (burn, fall, broken bone, auto, etc.)?

Did you ever have to stay in the hospital? Did you have any surgeries?

Do you have trouble with schoolwork?

Do you feel teased, picked on, bullied, threatened, left out? Do you ever think people are mean to you?

Did anyone close to you die? How? Did you ever lose a pet? How?

Did you ever lose something else that was special to you? What? How?