Kelly M. Chadwick, LCSW, LLC
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Child Client Confidential Information Form

Contact

Date: ______________________

Child's Name: ______________________

Mother: ______________________

Father: ______________________

Home Address: ______________________ OK to send mail? Yes No

City, State Postal: ______________________

Child D.O.B. / ______________ Age: ________ Grade: ________

Name of School: ______________________

	Call		Text		Voicemail	
Primary Contact Mobile Phone:	Yes	No	Yes	No	Yes	No
Primary Contact Work Phone:	Yes	No	Yes	No	Yes	No

Primary Contact Email Address: ______________________ OK to send email? Yes No

Emergency Contact Name: ______________________ Phone: ______________

Insurance

Carrier: ______________________ ID: ______________

Policy Holder Name: ______________________ Group: ______________

Relationship to Patient: ______________________ P. Holder DOB: ______________

Insurance Billing Address: ______________________

Demographic

Ethnicity: ______________________ Religious Affiliation: ______________________

Disability / Special Needs: ______________________

Adopted? If so, what age and birth country: ______________________

☐ I am requesting Christian based counseling ☐ I would like prayer incorporated into my sessions

Who referred you to me or how did you hear about me? ______________________

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Symptoms your child may be experiencing

- ☐ Feeling sad or depressed
- ☐ Crying spells
- ☐ Loss of interest &/or pleasure
- ☐ Bullied or Bullying others
- ☐ Weight gain or loss
- ☐ Too little sleep or too much sleep
- ☐ Difficulty falling asleep or staying Asleep
- ☐ Is risky or dangerous
- ☐ Is moody
- ☐ Bedwetting issues
- ☐ Nightmares / night terrors
- ☐ Sudden decrease in school performance
- ☐ Withdrawal from family or friends
- ☐ Wound up or tense more days than not
- ☐ Avoiding friends or family
- ☐ Decreased concentration
- ☐ Getting into trouble at school
- ☐ Anxiety
- ☐ Self-injurious behaviors / self-harm
- ☐ Panic attacks
- ☐ Abusing or using alcohol or drugs
- ☐ Irritability
- ☐ Fidgety, restless, overactive
- ☐ Easily fatigued
- ☐ Thoughts of death
- ☐ Unrealistic thoughts, fears, or worries
- ☐ Hopelessness
- ☐ Does not follow rules at home
- ☐ Repetitive, rigid, or strange behaviors
- ☐ Has frequent headaches
- ☐ Has frequent stomach aches
- ☐ Extreme aggression
- ☐ Destructive behavior (property damage, fires, etc.)
- ☐ Sexually Promiscuous
- ☐ Irrational fears
- ☐ Dangerous or impulsive behaviors
- ☐ Social issues / problems with peers
- ☐ Disrespectful to adults / authority figures
- ☐ Increase in goal activities or physical agitation
- ☐ Excessive involvement in activities that could result in negative consequences
- ☐ Eating or body image problems

Estimate the severity of the problem for which you are seeking care:

☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Current reason(s) for seeking therapy: ______________________________

____

____

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Family Life Challenges

- ☐ Experienced Adoption / Foster placement
- ☐ Current or past involvement with DSS
- ☐ Experience with incarcerated parent(s)
- ☐ Witness to domestic violence
- ☐ Medical illness or disability
- ☐ Experienced parental divorce
- ☐ Experience with parental drinking / drugs
- ☐ Experienced family financial problems
- ☐ Experienced death of a friend or family member
- ☐ Experience with illness in the family
- ☐ Experience with parental conflict(s)
- ☐ Experienced physical or emotional abuse
- ☐ Experienced a parent(s) military deployment
- ☐ Experienced a recent move to a new home/school
- ☐ Experienced a traumatic event
- ☐ Experienced sexual abuse

Health

Does your child have any medical conditions? (If yes, please provide details): ______________________

____

Has your child ever been hospitalized? (If yes, please provide details): ______________________

____

Is your child currently taking any medications? (Include medication, dosages, and prescribing doctor)

____

____

Has your child previously been in psychotherapy? Yes No

When and for what issues? ______________________________

____

Was it helpful to your child? (Why or why not?) ______________________

____

Does your child have any current or prior mental health diagnoses? ______________________

____

____

Does your child have any previous suicide attempts, self-destructive behaviors, or violent behaviors? (Please indicate their age, circumstances, and whether it led to hospitalization or legal problems)

Please list any past/present drug and alcohol use. What have you used and how much?

Is your child experiencing problems at school? (please provide detail)

Does your child have an Individualized Education Plan (IEP)? (please provide detail)

Is your child experiencing problems at home? (please provide detail)

Relationships

Please list everyone living in the home including children, friends, and family members

Name	Gender	Age	Please list any Social, Behavioral, or Health problems

Is your child experiencing any problems with peers?

Other

What would you like your child to accomplish in therapy?

What are your main worries or fears?

What do you consider your child's main strengths?

What are your child's primary challenges right now?

What are your most important hopes or dreams for your child?

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Clinical Summary

— Therapist Use Only —