

Lighthouse Counseling Center, P.C.

Child Questionnaire

(Client age thru 17) Rev. 10/09

This information will help your therapist understand your child better. This, as well as other communications with your therapist, will be kept confidential to the full extent of Georgia Law. **Proof of insurance coverage, guardianship & ID is required.**

Background information:

Today's Date: _____

Name of Child: _____ Age _____ DOB: _____ M / F

Residing Address _____ City _____ State: _____ Zip _____

Name of Person (s) child resides with _____

Relationship: Biological Parent(s) Step Parent Grandparent _____

Home Telephone _____ Cell/Work/Other _____

Contact number for messages from our office: _____

(Our office is not responsible for confirming appointments with you.)

ER Contact Name _____ Tel # _____ Relation _____

If parents/guardians are separated or divorced, how long? _____ Is Custody shared? Y/N

Other Parent/Guardian Name: _____ Tel: _____

Referral Source: _____ May we send a thank you? Y / N

School Name: _____ Grade _____

Insurance Information:

(Please print)

PRIMARY

SECONDARY

Insurance Company _____ / _____

Policy Holder's Name _____ / _____

Relationship to Client _____ / _____

ID Number _____ / _____

Group _____ / _____

SS # _____ / _____

Employer _____ / _____

Employer Telephone Number: _____ / _____

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Immediate Family Members: Name(s) Age(s) ✓ if lives w/client

Brother(s) _____

Sister(s) _____

Others living w/client _____ Relationship _____
_____ Relationship _____

In your own words, briefly describe the main problem, which prompted you to seek counseling for your child at this time.

Problem Areas: In the following list, place a check mark (✓) next to each item which identifies an area of *concern* to you. Place two checks (✓✓) by those items, which are *most important*.

- | | |
|--|--------------------------------|
| _____ Anger/Temper | _____ Sexual Concerns |
| _____ Depression | _____ Thoughts of Suicide |
| _____ Educational/School work | _____ Unhappy most of the time |
| _____ Family Problems | _____ Use of Alcohol |
| _____ Fearfulness/Phobias | _____ Use of Tobacco |
| _____ Physical Problems | _____ Panic Attack |
| _____ Insecure/Timid/Lack of Self Confidence | _____ Worry |
| _____ Divorce | _____ Traumatic Stress |
| _____ Problems with accepting discipline | _____ Stress |
| _____ Religious/Spiritual Concerns | |
| _____ Current substance use: _____ Marijuana, _____ Narcotics _____ Amphetamines | |
| _____ Methamphetamines _____ Cocaine _____ Hallucinogens _____ Acid _____ Prescription | |
| _____ Alcohol _____ Cigarettes. If checked, frequency of use: _____ | |

_____ Other: _____

Client Name: _____

Has your child ever been the victim of or witnessed any type of traumatic incident? If yes, please explain: _____

Medical History

List illnesses, surgeries, and injuries. Indicate age when occurred and describe how severe. _____

Has there been any previous counseling or psychological, psychiatric evaluations? _____
If so, please list names, addresses, and dates of contact.

Current medications: _____

When did the child last have a physical examination? _____

Name of Physician: _____

Address: _____

Describe any Developmental Problems (such as walking and talking): _____

Describe method of discipline used and how the child reacts to such discipline.

Describe child's appetite and eating habits at present. _____

Describe nervous habits such as thumb sucking, nail biting, etc. _____

Describe child's sleeping pattern now. Are there nightmares or night terrors now or in the past? _____

Describe child's level of activity _____

Describe any problems in attention or sitting still. _____

Food or drug allergies? _____

Academic/School Information

Name of School _____ Grade _____

Has child ever repeated a grade? _____ If so, when? _____

Have other family members had learning disabilities? _____

Describe what the child likes to do for fun, special interest, hobbies, etc. _____

We very much appreciate your cooperation in filling out this questionnaire. Please add any additional comments which you wish to tell your therapist.

I declare that I am the custodial parent **or** legal guardian of the child described in the document and that I have the legal authority to bring him or her for psychological treatment. Proof of guardianship or ID is available upon request by Lighthouse Counseling Center PC.

Signed _____ Relationship: _____

Print Name: _____ Date: _____

Signed _____ Relationship: _____

Print Name: _____ Date: _____