David Wilder, LICSW
Adult, Child, Adolescent and Family Psychotherapist/Counselor
CLIENT INFORMATION SHEET—Children and Adolescents

Today's Date: _____

Client/Child's Name: _____ Date of Birth: _____

Address: _____ Email:_____

Home Telephone: _____ Cell Phone: _____

Name of School/ Grade: _____

Mother/Guardian: _____ Father/Guardian: _____

Address: (if different than above) Address: (if different than above)

_____ _____

_____ _____

H Telephone: _____ H Telephone: _____

W Telephone: _____ W Telephone: _____

Cell Phone: _____ Cell Phone: _____

Profession: _____ Profession: _____

Email: _____ Email: _____

Step-Father: _____ Step-Mother: _____

Provide copy of insurance card or the following insurance information:

Insurance Co.: _____Subscriber ID#: _____

Co Pay : _____Coinsurance : _____

Effective date of Insurance:_____

(This information is not a guarantee of coverage, I will not know your exact benefits & coverage until I receive an explanation of benefits from your insurance company after first billing.)

Primary Care Physician

Name: _____ Phone: _____

Is there information that would be helpful for me to obtain from your PCP? Yes No

_____ ***OVER to Page 2***

Medical/Psychological Information

Birth History: Please check one.
___ Natural Delivery ___ C Section ___ Natural Delivery with Complications ___ Adoption
___ Other

If complications occurred, please explain:
_____

_____

Has your child been reaching her/his developmental milestones "on time"? Yes No
If no, please describe:

_____

_____

Is your child currently taking any medications? Yes No
If yes, please list the name of prescriber, medication and dosage:
_____
_____

Has your child ever received psychotherapy services **in the past**? Yes No
If so, with whom and when?_____

Please list any therapists and their phone numbers who are **currently** involved with your child:
_____

Has the above-listed client received medical or psychological diagnoses in the past? Yes No
If yes, please list diagnoses: _____

Please state the nature of your current concerns regarding your child and/or family:
_____

_____

_____

_____

Who has current legal custody of child?_____

With whom does the child presently live?

Name	Age	Relationship to Child

OVER to Page 3

Other adults involved with child rearing:

_____

Has your child ever been in any type of special education class? ___Yes __No
☐Learning disabilities ☐Resource room
☐Speech/Language Therapy ☐Other:_____

Has the child ever been:
☐Suspended from school ☐Expelled ☐Retained ☐Truant

Family History
Please note if any of these issues are present in your child's life or with your family:

ADD/ADHD_____
Allergies _____
Anxiety _____
Asthma _____
Autism_____
Bipolar Disorder _____
Criminal History _____
Depression _____
Divorce _____
Exposure to Domestic Violence _____
Head Injury _____
Physical abuse _____
Sexual Abuse _____
Sleep Disorder _____
Suicidal Thoughts_____
Substance Abuse _____
Victim of a crime_____
Other Health Concerns: _____