Northlight Counseling Associates, Inc.
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Phone: 602-285-9696 Fax: 602-277-5930

Child Information (Please Print)

Date: _____

Person(s) completing this form: _____ Relationship to child: _____

Child's name: _____ Birth date: _____ Age: _____

Child's address: _____ City: _____ State: _____ Zip code: _____

List only phone numbers that we may contact you or leave a message.

1. Contact Name: _____ Relationship to Child: _____
Home Phone: _____ Work Phone: _____Cell Phone: _____

2. Contact Name: _____ Relationship to Child: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

3. Emergency Contact Name: _____ Relationship to Child: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insurance Information for Child (Please do not leave blanks; must be completed)

Is this an Employee Assistance Program Benefit? ____ Yes ____ No Authorization #: _____

Medical Health Plan: _____ Benefits Info Phone # _____
ID Number: _____ Group Number: _____
Subscriber's First and Last Name: _____ Gender ____Male ___Female
Subscriber's DOB: _____ Relationship to Child: _____
Employer: _____ Referred By: _____

Secondary Insurance: _____ Benefits Info Phone #: _____
Subscriber's First and Last Name: _____ Gender ____Male ___Female
Subscriber's DOB: _____ Relationship to Client: _____
Employer: _____ Referred By: _____

I authorize my insurance company to pay Northlight Counseling Associates, Inc. directly for services rendered, for my children, my ward, my spouse and me. I authorize the release of any information pertinent to my case to any insurance company or adjustor involved in this case. A photocopy of this Assignment shall be considered as effective and valid as the original. *This is a direct assignment of my rights and benefits under the policy.* I also authorized Northlight Counseling Associates, Inc. to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I understand that the filing of a claim to my insurance company is a courtesy to clients.

Signature: _____ Date: _____
SIGNATURE OF CUSTODIAL PARENT OR LEGAL GUARDIAN

Family History:

1. Circle who child is living with:

Both parents Mother Father Grandparent(s) Step-parent Legal Guardian

Other: _____

2. Circle status of parents' relationship:

Married Separated Divorced Widowed Never Married

How long married: _____ How long divorced? _____ Child's age at divorce _____

If divorced: <u>Please note – copy of the court documents are required and will be part of the child's chart</u>

Legal Custody: 50/50 ___ Yes ___ No If no, primary legal parent _____
Physical Custody (please fill out percentage) Mother _____ Father _____
How is child's time currently divided: _____

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3. List the adults and children who live in the child's home:

Name:	**Age:**	**Sex: M/F**	**Relationship to child: (step, foster, adoptive, etc.)**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical History:

Pediatrician's Name: _____ Phone Number: _____

Has your child been taken to the emergency room, hospitalized or had outpatient surgery since birth? ___ Yes ___ No
If yes, please describe: _____

Has your child had a head injury? ___ Yes___ No If yes, how many? ____
Did your child lose consciousness? ___ Yes ___ No
How did it happen: _____
_____

Has your child been diagnosed with a chronic health condition? ___ Yes ___ No
If yes, please describe: _____
_____

Does your child take any medication on a regular basis? ___ Yes ___ No
If yes, please list medication name and dosage: _____
_____

Educational History:

Name of school client attends: _____ Grade: _____

Do you feel your child is learning up to his or her potential? _____ Yes _____ No
If no, please indicate the academics that are underdeveloped:_____
_____

List any extracurricular activities your child is or has been a participant: _____
_____
_____

Are any of the following concerns or problems your child has in school? Place a check to the left of the item that applies to your child.

	Does not do homework
	Excessive time to complete assignments
	Gets distracted easily
	Poor handwriting
	Forgets assignments
	Test anxiety
	Has trouble staying seated
	Starts but does not finish homework
	Noncompliant in class
	Incomplete classroom work
	Excessive talking
	Messy/disorganized
	Poor attention in class
	Makes careless mistakes/Ignores details
	Fidgets/Squirms
	Runs/climbs excessively or restless
	Can't play or relax quietly
	Feels "on the go"/Driven by a motor
	Blurts answers
	Interrupts/Intrudes
	Difficulty awaiting turns

Has your child been retained a grade? ___Yes ___ No If yes, which grade? _____
Does your child have?

1. **Learning disability _____ Yes _____ No Subjects: _____**
2. **Language disorder: ___ Yes _____ No Type: _____**
   If yes to 1 or 2, who provided the diagnosis and how old was your child when diagnosed. _____

Does your child currently have a ___ IEP ____504 _____ Other health impaired services. Please describe _____
_____

Birth, infancy and early childhood Developmental History:

	Yes	No	Describe
Medical problems during pregnancy?			
Medications during pregnancy?			
Substances used during pregnancy? **Cigarettes? How many? How often?** **Alcohol? How many drinks? How often?** **Drugs? Type and frequency of use.**			
Other problems during pregnancy?			
Any birth complications?			
Was child born premature? **If so, how premature?**			
Birth weight and length?			
Breast-fed? **If so, how long?**			
Was child allergic to medications, food, etc.?			
Sleep patterns or problems?			
Any event, health condition, separation etc., disturb early infant mother bonding or the developing toddler?			
Any event, health condition, separation etc., disturb early infant father bonding or the developing toddler?			
Any concerns with gross motor development? (e.g., running, skipping, jumping)			
Any concerns with fine motor development? (e.g., writing, buttoning, zippering)			
Any speech or hearing difficulties? **If yes, did your child receive speech therapy? If yes, what age?**			
Were any developmental milestones difficult or slow to develop for your child? (e.g., sitting without support, crawling, eating, dressing self, talking, potty training, riding a bike, tying shoes)			

Place a check in the box to the right of the behavior that best describes your child during infancy and early childhood.

Quiet and content		**Colicky and irritable**	
Very easy to feed		**Daily feeding problems**	
Slept well		**Frequent sleeping problems**	
Usually relaxed		**Often restless**	
Underactive		**Overactive**	
Cuddly, easy to hold		**Did not enjoy cuddling**	
Easily calmed down		**Tantrums, head banging**	
Cautious and careful		**Accident prone, dare devil**	
Coordinated		**Uncoordinated**	
Enjoyed eye contact		**Avoided eye contact**	
Liked people		**Disliked contact with other people**	

Place a check in the box to the right if your child has experienced any of the following:

Death of a family member? If yes, who?		**Death of a friend?**	
Death of a pet?		**Moved?**	
Best or close friend moved?		**Nightmares?**	
Eating issues?		**Frequent headaches?**	
Stomachaches?		**Frequent illnesses?**	
Fire setting?		**Torturing animals?**	
Accident?		**Witnessed violence?**	
Physical Assault?		**Sexual Assault?**	

Child's temperament, traits and social interactions:

	Yes	No	Describe
Is your child overactive?			
Does your child have trouble paying attention?			
Does your child have trouble staying with an activity?			
Does your child have fluctuating moods?			
Does your child get frustrated easily?			
Are your child's emotional responses generally unpredictable?			
Does it take your child a long time to warm up to new situations/people?			
Does your child react strongly to physical pain?			
Does your child react strongly to other things?			
Any problems in the following areas?			
Discipline			
Temper or fighting			
Risky behaviors			
Argumentative			
Mean, Aggressive			
Angry			
Irritable			
Manipulative			
Cries easily			
Shy or timid			
Impulsive			
Worrier			
Impulsive			
Fears making mistakes			
Teasing or bullying			
Has been or is being teased or bullied			
Peer rejection			
Popular with peers			
No friends			
Few friends			
Bossy, controlling with friends			
Loses friends			
Trouble making friends			

Has your child or any of your family members struggled with any of the following? Check all that apply.

Condition	Child Current	Child Past	Mother	Father	Sibling	Other
Depression, sadness						
Anxiety, Excessive worries, irritability, decreased concentration/focus, restless easily fatigued						
Obsessions/Compulsions						
Tic: vocal/motor						
Headaches						
Suicidal Thoughts						
Attempted Suicide						
Learning Disability						
ADD/ADHD						
Problems with Anger						
Problems with Assertiveness						
Opposition/Defiance (child/adolescent only), loses temper, argues with adults, actively defies adults, deliberately annoys others, blames other for own mistakes, spiteful, vindictive, resentful, easily annoyed						
Conduct d/o (child/adolescent only), Bullies, threatens, starts physical fights, physically cruel to people/animals, stolen, fire setting, property destruction, lying, cons, stays out at night w/o parents						
Problems with the law						
Schizophrenia/Psychosis						
Nervous Breakdown						
Alcohol use						
Drug use						
Eating disorder						
Abuse/Neglect						
Self harm behaviors						
Social anxiety						
Sleep problems						
Dreams/nightmares						
Phobias/Fears						

Trauma witnessed/experienced						
Other						

Social Media and Technology: Complete the following:

Social Media/Technology	Yes	No	Monitor Yes/No	Total hours weekday	Total hours weekend
Computer					
IPad/Tablet					
Cell phone					
Gaming system					
Texting					
Snapchat					
Instagram					
Email					
Facebook					
Twitter					
Youtube					
Gaming					
TV/Movies					
Other					