Dr. Seima Diaz, Ed.D, LMFT
Licensed Marriage Family Therapist #MFC89056

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CHILD CLIENT INFORMATION FORM

(please complete both sides)

Name of Child: _____

Address: _____

_____

Birth date_____ **Age** _____ **School & Grade** _____

Custody Status (if applicable) _____

Who referred you? _____ May we contact this person? _____

In case of an emergency, contact…

Name _____ Relationship to child _____ Phone _____

Family Members: *(please list everyone living with the client.)*

Name	Birthdate	Relationship to child

Mother's Information

Name _____ Date of Birth _____

I am: _____Biological mother _____Stepmother _____Adopted mother _____Other:_____

Address _____

_____

Home phone _____ Cell Phone _____ Email Address _____

Can a message be left at any or all of the numbers? Home _____ Cell _____

Marital Status: ___Married ___Remarried ___Single Parent ___Widow ___Divorced ___Separated

Mother's religious affiliation _____

Father's Information

Name _____ Date of Birth _____

I am: _____Biological father _____Stepfather _____Adopted father _____Other:_____

Address _____

_____

Home phone _____ Cell Phone _____ Email Address _____

Can a message be left at any or all of the numbers? Home _____ Cell _____

Marital Status: ___Married ___Remarried ___Single Parent ___Widower ___Divorced ___Separated

Father's religious affiliation _____

What type of services are you currently seeking for your child? Please mark an "X" by the type of services you are seeking.
Individual therapy _____ Marital/Couples therapy _____ Family therapy _____ Group Therapy _____
Other (describe) _____ Unsure _____

Payment Information: Please indicate how you intend to pay for treatment: Cash: ___ Check: ___ Credit Card: ____
Insurance: _____ Third-Party: _____. If a third-party will be paying for your treatment, please provide the following information: Name of the person paying for your therapy: _____
Your Relationship to this person: _____
Contact Information for this person: _____

Goals of Treatment:
What compelled you to seek therapy at this time for your child?

_____

_____

_____

Describe your current concerns, issues, or problems that you hope for your child to resolve:

_____

_____

_____

What do you hope your child will gain from therapy?

_____

_____

_____

Symptoms & Concerns:

Please check any that apply to your child and circle those that are the most significant.

____ Adjustments (changing schools, pet died, parents divorce or marriage, new sibling etc.)
____ Learning difficulties
____ ADHD symptoms
____ School problems
____ Peer/social problems
____ Parent-child relationship problem
____ Non-family relationship problem
____ Abuse or assault victim
____ Difficulty separating/dependent
____ Health concerns (physical symptoms)
____ Sleeping difficulties
____ Nightmares
____ Eating Problem
____ Physical disability
____ Chronic illness
____ Terminal illness
____ Trauma
____ Bed wetting
____ Encopresis/enuresis (elimination problems)
____ Anxiety/worry
____ Sadness/Depression
____ Obsessive/Compulsive
____ Mood changes
____ Defiance
____ Lying
____ Anger/irritability
____ Addiction
____ Suicidal thinking
____ Aggression/violence

Please describe any of the above in more detail or any other concerns you have regarding your child

_____

_____

_____

If your child has ever seen a mental health professional (psychiatrist, psychologist, or counselor), please list when, who, and why they were seen.

_____

_____

_____

Is your child currently taking any medications? If yes, please list and explain_____

_____

Primary Care Physician Name, phone number: _____

Spiritual/Cultural History:

Does your child identify with a particular religion, culture, or spiritual practice? If so, please describe:

_____

_____

_____

Do any of the above religious, cultural, or spiritual issues contribute to your child's current concerns, problems, or issues? If so, please describe:

_____

_____

_____

Additional Information:

Please let me know in the space provided, of anything that was not addressed in this intake, and anything that you would like me to know about your child, your child's goals, your child's relationships, or any recent significant life events your child has experienced:

_____

_____

_____

Signatures: I certify that the information provided above is accurate to the best of my knowledge. If any of the information changes, I will provide updated information to Dr. Seima Diaz, Ed.D, MFT as soon as possible.

_____ _____

Mother's Signature Date

_____ _____

Father's Signature Date