



# Child Registration Form

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Date

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Child's Name Date of Birth

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Parent's Name Father Mother

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Address: Street City State Zip

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Date of Parent's Marriage(s), Separation(s), and Divorce(s)

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Level of Education: Father Mother

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Others Living at Home: Sex Birth Date School & Grade

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Others Living at Home: Sex Birth Date School & Grade

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Others Living at Home: Sex Birth Date School & Grade

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Others Living at Home: Sex Birth Date School & Grade

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Father's Employer Occupation

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Mother's Employer Occupation

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Family Physician

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Referred By

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Primary Complaint and Problem

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# Developmental History

- Yes  No Was pregnancy planned?
- Yes  No Was there complications?  
What? \_\_\_\_\_
- Complications of birth and delivery \_\_\_\_\_
- Yes  No Is child adopted?  
Age if/when adopted \_\_\_\_\_
- Yes  No Problems with feeding, eating, sleeping?  
When did they start? \_\_\_\_\_  
Duration? \_\_\_\_\_
- Yes  No Have there been any physical or emotional separations (i.e. death, hospitalizations, depression) between child and caretaking adult during the first 26 months of life?
- Yes  No Is there, as far as you know, any possible history that could be considered abusive?  
Please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If it is hard to remember ages please simply check the problem area or areas you feel were/are advanced or slow in development:

<i>Age he/she:</i>	<i>Does he/she:</i>	<i>Is he/she:</i>
Held head up _____	Have blank spells _____	Shy or timid _____
Crawled _____	Rock _____	Affectionate _____
Walked with help _____	Shun attention _____	Well-coordinated _____
Used sentences _____	Have temper tantrums _____	Impulsive _____
Fed self _____	Have falling spells _____	Right-or left-handed _____
Dressed alone _____	Have unusual fears _____	Clumsy _____
Turned over _____	Bump head _____	
Sat _____	Hold his/her breath _____	
Walked alone _____	Show daredevil behavior _____	
Was weaned _____	Have sleep problems _____	
Said "No" to everything _____	Have eating problems _____	
Smiled at parents _____		
Pulled up at crib _____		
Said 4-10 words _____		
Helped with dressing _____		
Dry during day _____		
Dry during night _____		

\_\_\_\_\_  
Previous testing or therapy

\_\_\_\_\_  
Dates

\_\_\_\_\_  
Place

\_\_\_\_\_  
Findings

# School Information

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School of Patient

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Grade

Teacher

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Year Enrolled

School Telephone Number

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School Social Worker or Psychologist

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Previous Schools

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Please fill in where appropriate:

*My child has been:*

Tutored in \_\_\_\_\_  
Date \_\_\_\_\_  
Enrolled in special class \_\_\_\_\_  
Which class \_\_\_\_\_  
Expelled \_\_\_\_\_  
Date \_\_\_\_\_  
Suspended \_\_\_\_\_  
Date \_\_\_\_\_  
Commendations & awards \_\_\_\_\_

*I have been told by the school that my child:*

Gets along well with adults \_\_\_\_\_  
Gets along poorly with adults \_\_\_\_\_  
Gets along poorly with students \_\_\_\_\_  
Procrastinates \_\_\_\_\_  
Has few friends \_\_\_\_\_  
Is bored \_\_\_\_\_  
Is above/below average IQ \_\_\_\_\_  
Is "hyperactive" \_\_\_\_\_  
Has trouble on bus/playground \_\_\_\_\_

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Repeated grade \_\_\_\_\_  
Cuts class \_\_\_\_\_  
Frequently \_\_\_\_\_  
Cutting class since \_\_\_\_\_

## Family Information (Optional)

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Who wanted help?

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Five adjectives describing mother

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Five adjectives describing father

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Five adjectives describing parental relationship

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Mother's main concern

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Child's main concern

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ABUSE/NEGLECT HISTORY – CLIENT AND/OR OTHER CHILDREN WITHIN FAMILY OF ORIGIN

Mark one response to indicate whether or not a child / youth in the family has experienced:

Physical Abuse/Assault	Yes	No	Unknown	Emotional Abuse	Yes	No	Unknown
Sexual Abuse	Yes	No	Unknown	Neglect	Yes	No	Unknown
NARRATIVE: <b>For all Yes</b> responses provide narrative including, but not limited to: whether the incident(s) happened to the client and/or the client: initiated the incident(s), whether suspected/alleged/ founded, nature of abuse/neglect, frequency, relationships of involved individuals, and client's age at beginning and ending of incidents. <b>For all Unknown responses, explain.</b>							

CLIENT PLACEMENT HISTORY

If applicable list every placement of client beginning with Family of:

Agency and/or Name	Date of Entry	Date of Discharge	Reason for Discharge

Additional Information:

**(Does he/she)**

Have blank sells?		Rock?		Shun Attention?		Have temper tantrums?		Have falling spells?	
Have unusual fears?		Bump head?		Hold his/her breath?		Show dare devil behaviors?			
Have eating problems?		Act shy or timid?		Overly affectionate?		Well coordinated?			
Act clumsy?		Right or left handed?		Act impulsively?		Have sleep problems?			

**C. HISTORY OF MENTAL HEALTH EVALUATIONS AND TREATMENT**

**CURRENT AND/OR PRIOR MENTAL HEALTH TREATMENT – CLIENT**

inpatient

**I I** residential

Outpatient

For each treatment type checked specify:

Presenting Problem – Reason for Treatment	Agency, Therapist, Treatment Type, Program	Date Start	Date End	Outcome

ADDITIONAL INFORMATION: (Include history of diagnoses)

CURRENT USE OF PSYCHOTROPIC MEDICATION					If none, check here and skip to next module.	
CLIENT						
Name	Dose	Frequency	Side Effects	Date Started	Focus of Treatment	Outcome

ADDITIONAL INFORMATION:

PREVIOUS USE OF PSYCHOTROPIC MEDICATION					E none, check here and skip to next module	
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CLIENT						
Name	Dose	Frequency	Side Effects	Date Started	Focus of Treatment	Outcome

ADDITIONAL INFORMATION:

CURRENT AND/OR PRIOR MENTAL HEALTH EVALUATION AND OR TREATMENT – FAMILY If none, check here and skip to next module .  
 NARRATIVE: Including but not limited to: specification of the family member(s) by name, **presenting problem(s), treatments** received or lack of treatment outcome sl. dates, history or diagnoses and medications.  
 Please attach additional sheets.

**PARENTS' AUTOBIOGRAPHIES:** For each parent involved in the child's life, please write down your autobiography in paragraph form, covering the following areas and any other areas you believe are or were significant in your life.

**FAMILY OF ORIGIN:**

- Describe your mother and father (including both strengths and weaknesses).
- How did your parents show affection to each other and their children?
- Describe your parents' marital history.
- Describe your parents' parenting philosophy.
- Describe your parents' means of motivation / discipline.
- Describe the communication style of your family origin.
- How did your parents handle disagreements and conflicts?
- How many siblings did you have and what role did each sibling play in the family dynamics?
- Do you see any family patterns being repeated in your current family or in your siblings' current families?
- Describe any changes in your family of origin, including moves, job changes, significant events, deaths, separations from parents, divorce, major illness, or injuries.
- Describe your early childhood. Include any illnesses, hospitalizations, injuries, separations from parents. Include any significant memories favorite activities, etc.

**CURRENT FAMILY:**

- Describe your current marriage (include both strengths and weaknesses).
- Write a brief description of any previous marriage(s).
- Describe your parenting philosophy.
- Describe your means of motivation / discipline.
- Describe any differences in your parenting styles.
- Describe your communication styles.
- How are decisions made?
- Describe any current significant medical problems.
- List your children and give a brief description of each child.
- What concerns do you have with any other member of the family?
- Describe your family's support system.
- Describe your family's involvement in outside activities.
- How large a role (if any) does religion play in your family?
- Describe your family's lifestyle.

**Please attach additional sheets for each autobiography.**



**BIRTH PARENT SIGNIFICANT RELATIONSHIP HISTORY:** Complete this section for each adult listed in "Parental Figures – Family of Origin"

Parental Figure Name:			
History unknown		Parent reports no significant intimate relationships	
NARRATIVE: Including, but not limited to duration of relationship/ dates, relationship type [e.g. married, living together not married, etc. and significant dynamics of relationship. Indicate in chronological order from most to least recent.			
Please attach additional sheets.			
Parental Figure Name:			
History unknown		Parent reports no significant intimate relationships	
NARRATIVE: Including, but not limited to duration of relationship/ dates, relationship type [e.g. married, living together not married, etc. and significant dynamics of relationship. Indicate in chronological order from most to least recent.			
Please attach additional sheets.			

**A DAY IN THE LIFE OF OUR CHILD**  
**CLIENT (CHILD) SIGNIFICANT PEER RELATIONSHIP HISTORY, ACTIVITIES, HOBBIES &**  
**INTERESTS NARRATIVE:**

Please include the following information in this description:

- Describe your child’s typical behaviors
- Describe how you would typically respond to these behaviors
- Describe the interaction between your child and siblings and/or peers
- Which of your child’s behaviors bothers you the most?
- Describe your child’s school behaviors and response to authority
- Describe the communities (teachers, neighbors, friends, family) reactions to your child’s behavior and to your parenting interventions
- Describe how your child relates to Mother, Father
- Describe what impact this child has had on your marriage, your family, your lifestyle, your personal well-being. (answer for each member of the family)
- Which of your parenting techniques seems to be the most effective? The most ineffective? What have you tried?
- How are you feeling? (answer for each member of the family)
- Does anyone in your family feel physically threatened?
- What are your worst fears?
- What are your best ones?

**Please attach additional sheets.**