

*Bridges and Pathways Counseling Services*  
*Twin Cities*

Today's Date: \_\_\_\_\_ **Parent Information for Child Client**

In order to provide the best services possible, please complete the form below. If you need more space than we have provided, please use the back of the last page.

How did you hear about us?  Doctor  Insurance/EAP  Family Friend  Internet  Ad in paper  Building Sign  
 Other \_\_\_\_\_

Child's Name	Date of Birth	Age
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**Parents/Guardians:**

Mother's Name	Age	Occupation
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Father's Name	Age	Occupation
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Person answering questions: \_\_\_\_\_ Primary caregiver: \_\_\_\_\_

Who does the child live with? \_\_\_\_\_ How long in current living situation? \_\_\_\_\_

**Why are you seeking help for this child?**

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**Behaviors or Symptoms that you have observed or are concerned about for your child:**

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**When did these concerns begin?**

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Has this child experienced any parental separation?  No  Yes; if yes, When? Child's age ? Circumstances?

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Parents are:  together  separated  divorced  military/job separation  never married, living separately

If no longer living together, when did this occur? \_\_\_\_\_

Who has legal custody of this child? \_\_\_\_\_

Who has physical custody of this child? \_\_\_\_\_

**Parenting Time Schedule:** \_\_\_\_\_

\_\_\_\_\_

**Concerns regarding Parenting Time Schedule:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Does this child have siblings?**  No  Yes; if yes, list their names, ages, and where they are living

\_\_\_\_\_

\_\_\_\_\_

**Concerns about family relationships?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**What do you enjoy most about this child?**

\_\_\_\_\_

\_\_\_\_\_

**What do you find most difficult about raising this child?**

\_\_\_\_\_

\_\_\_\_\_

**Any other family changes, transitions, or stresses your child may be experiencing:**

\_\_\_\_\_

\_\_\_\_\_

**Developmental History:**

Did you have problems during pregnancy? \_\_\_\_\_

Please describe your child's activity level, behavioral, social, and emotional adjustment:

As an infant: \_\_\_\_\_

As a toddler: \_\_\_\_\_

As a preschooler: \_\_\_\_\_

During grade school: \_\_\_\_\_

During junior high: \_\_\_\_\_

During high school: \_\_\_\_\_

**Describe any concerns or delays your child had with regards to:**

Crawling/walking as an infant/toddler: \_\_\_\_\_

Delays or concerns regarding speech development: \_\_\_\_\_

Concerns regarding bowel/bladder training/bed wetting: \_\_\_\_\_

Concerns you had about your child's eating and sleeping patterns: \_\_\_\_\_

Adjustment to separations before school age: \_\_\_\_\_

Observations or concerns regarding social skill development: \_\_\_\_\_

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**Concerns regarding friendships and social skills:** \_\_\_\_\_

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**Concerns regarding your child's use of internet and social media:** \_\_\_\_\_

**Medical History:**

Medical concerns and medication history: \_\_\_\_\_

Allergies: \_\_\_\_\_

Child's physician's name and phone number: \_\_\_\_\_

**Past Therapy:**

Clinician's Name: \_\_\_\_\_ Dates of Service: \_\_\_\_\_

Reasons for therapy and outcomes: \_\_\_\_\_

**Academic Concerns:**

School: \_\_\_\_\_ Grade \_\_\_\_\_

Name of Teacher: \_\_\_\_\_

**Academic, behavioral, emotional or social problems occurring at school:** \_\_\_\_\_

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**Other comments or concerns:** \_\_\_\_\_

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**Your Expectations: (What do you hope your child will gain from therapy)**