Bridges and Pathways Counseling Services
563 Bielenberg Drive, Suite 125
Woodbury, MN 55125
Phone: 651-829-6610 Fax: 651-739-1998

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**

Parents/Guardians:

_____ _____ _____
Mother's Name **Age** **Occupation**

_____ _____ _____
Father's Name **Age** **Occupation**

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?

_____
_____
_____
_____

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

_____
_____
_____

When did these concerns begin?

_____
_____
_____
_____

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

_____
_____
_____

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:_____

_____

_____

Concerns regarding friendships and social skills:_____

_____

_____

_____

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: _____

_____

_____

_____

Other comments or concerns: _____

_____

_____

_____

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

_____

_____

_____

_____

_____