Insight Integration LLC
counseling and art therapy

# Child Client Information Sheet

Client's name: _____

Date: _____

Child's School and Teacher Name:

_____

Birth Date: _____

If a minor, Guardian's Name_____

Address: _____

City, State: _____ Zip: _____

Phone numbers with area code

Cell: (  ) _____

Birth date: _____ Age: ____

Position: _____ for how long? _____

Education: _____

Marital/relationship status: _____ Significant other's name: _____

Significant other's age and sex: _____ How long together? _____

Names and ages of all children in the home: _____

How did you hear about Insight Integration, LLC/ Noel Simmons, MA?

_____

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# Medical and Health History

Name: _____ Date: _____

List any allergies your child has: _____ None_____

Pediatrician: _____Address:_____

City: _____ State: _____ ZIP: _____

Pediatrician's phone number: (____) _____

Date of your child's most recent physical examination: _____

**Please list all current medications and dosages:**

| Name of Medication | Dosage | Name of Prescribing Doctor | When did they start taking it? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Please list all current or past health problems, and any major operations:**

| Current | Past |
|---|---|
| | |
| | |
| | |
| | |

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List any occupational therapy, mental health, learning disability treatment your child has had and the dates: _____

List any significant shift in your child's life in the last 3 years (divorce, re-location, etc.):
_____
_____

What kind of issue brings you to Insight Integration, LLC?
_____
_____

Please indicate if you are having any of the following problems, or if you had them in the past:

| I have this now | I had it in the past | |
|---|---|---|
| ☐ | ☐ | Difficulty falling asleep or staying asleep |
| ☐ | ☐ | Change in appetite, weight loss, or weight gain |
| ☐ | ☐ | Frequent crying |
| ☐ | ☐ | Panic attacks or anxiety attacks |
| ☐ | ☐ | Thoughts of killing or hurting myself |
| ☐ | ☐ | Attempts to kill or hurt myself |
| ☐ | ☐ | Problems concentrating |
| ☐ | ☐ | Problems remembering things |
| ☐ | ☐ | Periods of daily sadness lasting more than two weeks |
| ☐ | ☐ | Startle easily |
| ☐ | ☐ | Difficulty/can't stop remembering upsetting past events |
| ☐ | ☐ | Difficulty controlling my temper |
| ☐ | ☐ | Physically hurts other people |

Other (please list):
_____
_____
_____

_____
Signature Date

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