INNOVATIVE FAMILY THERAPY

PARENT INFORMATION FORM

CHILDS NAME: _____ DOB: _____

ADRESS: _____

SCHOOL: _____GRADE: _____

(If address is same for both indicate as "same")

MOTHERS NAME: _____ DOB: _____

ADDRESS: _____

PHONE: _____ (*indicate if # is cell, work, home or other)*

EMAIL: _____

FATHERS NAME: _____ DOB: _____

ADDRESS: _____

PHONE: _____(*indicate if # if cell, work, home or other)*

EMAIL: _____

Is there a custody agreement between parents YES NO

If you have joint custody or any other arrangement please provide a copy of the custody agreement to your therapist the day of your first appointment or you can mail or email beforehand.

Do you have custody of your child & the right to make medical decisions such as them receiving therapy services?

YES NO

WOULD YOU LIKE TO RECEIVE APPOINTMENT TEXT REMINDERS? YES NO

HOW DID YOU HEAR ABOUT THE PRACTICE? _____

If referred by someone; may I thank this person for the referral? YES NO

EMERGENCY CONTACT: _____ PHONE: _____

RELATIONSHIP: _____

SIBLING INFORMATION

SIBLING NAME	AGE	SCHOOL	GRADE

What school is your child currently attending? _____ What grade? _____

Is your child currently receiving special services in this school? YES NO

If yes pleas specify:_____

Has your child ever failed a class or been held back for academic or developmental reasons? YES NO

If yes explain: _____ what grade:_____

Is your child currently passing in school? YES NO

If no please explain: _____

CHILD DEVELOPMENT HISTORY Date:_____

CHILD'S NAME: _____ AGE: _____ DOB:_____GENDER: _____

Please answer the following questions to the best of your ability by circling yes or no and explaining when necessary. If you do not know the answer please indicate by writing UNKNOWN.

1. What was your child's birth weight? _____lbs. _____oz.

1. What type of delivery? Natural birth Cesarean

Was the delivery normal? Were there any complications? YES NO

If yes please explain: _____

3. Did the birth mother experience any complications during pregnancy? YES NO

If yes please explain:_____

4. Did the birth mother experience any emotional problems during pregnancy? YES NO

If yes please explain:_____

5. Were there any mediations taken during pregnancy? YES NO

If yes please specify:_____

6. Were there any alcohol or substance abuse during pregnancy? YES NO

If yes please specify: _____

7. Did the infant experience any medical problems immediately after birth? YES NO

If yes please explain:_____

8. Has your child ever required hospitalization? YES NO

If yes please explain:_____

9. Is there any history of physical, emotional, or sexual abuse? YES NO

If yes please explain:_____

10. Has your child ever been diagnosed with a physical or mental disability? YES NO

If yes please explain:_____

11. Has your child ever experienced any traumatic events or prolonged separations from parents or family? YES NO

If yes please explain: _____

Please specify at what age your child hit these developmental milestones. (*Italicized areas reflect average development ages)*

_____ Smiled (*1 to 2 mo.)* _____ Held head up (*3 to 4 mo.)* _____ Rolled over (*4 mo.)*

_____ Sat alone *(6 to 10 mo.)* _____ Crawled (*6 to 10 mo.)* _____ Pulled up to stand *(6 to 10 mo.)*

_____ Walked by themselves *(12 mo.)* _____ First words (*10 to 12 mo.)* _____Talked in single words *(18 mo.)*

_____Fed self (*1 to 2 yrs*) _____ Talked in sentences (*2 yrs*) _____ Established toilet training (*2 to 4 yrs*)

_____ Dresses self (2 to 2 1/2 yrs) _____ Rode a bike (6 yrs)

How would you describe your child's approach to new experiences/situations?

_____

How would you describe your child's overall mood?

_____