Child Client Information
For Children up to 16 Years Old

Today's Date: _____ **Contact Number:** _____ ☐ Cell ☐ Landline ☐ Male ☐ Female

First Name: _____ **Last Name:** _____ **DOB:** _____ **Age:** _____

Address: _____ **Email:** _____
Number and Street City State Zip

Main Contact(s): *(If not the client, list other contacts' name, relationship, cell phone and email address:)*

Messages:
If we call you, may we leave a message with someone else? ☐ Yes ☐ No
May we leave a voicemail message? ☐ Yes ☐ No
May we send appointment reminders: ☐ Text ☐ Email ☐ Both ☐ None

Goals for training or primary problem(s) you'd like to improve:

Other providers helping with these issues *(please provide contact details)*

How did you hear about us?
☐ *Medical professional ☐ *Mental Health professional
☐ Friend or acquaintance ☐ Facebook ☐ Internet search ☐ Article or ad
☐ Psychology Today ☐ Center for Brain Training website ☐ Informational Seminar

If medical or mental health professional, please provide name, city, state

List all prescribed medications, how long you have been on them and any comments:

List all supplements/OTC medications, how long you have been on them and any comments:

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First Name: _____ **Last Name:** _____ **Date:** _____

What brings you here today? ☐ ADHD ☐ Attention Issues ☐ Anxiety ☐ Sleep ☐ Behavior or mood
☐ Processing or cognitive difficulties ☐ _____

Handedness: ☐ Right ☐ Left ☐ Ambidextrous

Which of these have you experienced?
☐ Hit head ☐ Concussion
☐ Been in car or bike wreck ☐ None

More explanation: _____

Sleep Patterns:

What time does your child typically fall asleep _____

How long to fall asleep*? (minutes/hours)* _____

Wake up easily?	☐ Yes	☐ No	☐ Sometimes	☐ Never or almost never
Typically sleep through the night?	☐ Yes	☐ No	☐ Sometimes	☐ Never or almost never
Wake feeling rested?	☐ Yes	☐ No	☐ Sometimes	☐ Never or almost never

Comments about your sleep:

Are you sensitive to caffeine? *(Chocolate, cola, tea, coffee)* ☐ Yes ☐ No

Does caffeine make you… ☐ Alert/awake ☐ Jittery/wired/hyper ☐ Relaxed ☐ No effect

Is there any history of using recreational drugs? ☐ Yes ☐ No

If yes, explain:

Has there been any psychiatric or mental health diagnoses? ☐ Yes ☐ No

If yes, explain:

Has there been any hospitalizations related to a psychiatric or mental health issue? ☐ Yes ☐ No

If yes, explain:

Is there any history of any suicidal thoughts or thoughts of self-harm? ☐ Yes ☐ No

If yes, explain:

Child History

First Name: _____ **Last Name:** _____ ***(Fill out what you can)***

Provide any important family history issues related to child (divorce, disruptions in family, loss of family, adoption, foster, etc.)

History of help utilized:

- ☐ Counseling or behavioral therapy
- ☐ Occupational therapy
- ☐ Tutoring
- ☐ Speech
- ☐ Medications
- ☐ Special diets or nutrition

Additional comments:

Any IEP or 504 plan or accommodations?

Greatest Strengths:

Any developmental or other early relevant history:

PHYSICAL: ☐ Headaches ☐ Stomach issues ☐ Constipation _____ # of rounds of antibiotics in child's life

Does the child GET ALONG well with…?					Comments:
	Parents/step-parent/guardian	☐ Yes	☐ No	☐ Sometimes	
	Siblings	☐ Yes	☐ No	☐ Sometimes	
	Friends and peers	☐ Yes	☐ No	☐ Sometimes	
	Teachers	☐ Yes	☐ No	☐ Sometimes	

ACADEMICS: Is the child doing well academically? ☐ Yes ☐ No

Is the child behind grade level in ☐ Reading ☐ Math ☐ Spelling ☐ Other Subjects

Are there other subjects the child struggles with more with than others?

Does your child avoid activities? ☐ Yes ☐ No If yes, explain:

Does your child have difficulty shifting from one activity to another (transitioning)? ☐ Yes ☐ No

How would you describe this child?

Does your child have healthy self-esteem? ☐ Yes ☐ No

Does your child have excessive sensitivity to light/sound/noise? ☐ Yes ☐ No