

Northside Center for Emotional Wellness LLC

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Minneapolis, MN 55412

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**CHILD INFORMATION FORM**

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**:Current medications being taken:

1)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage/Freq \_\_\_\_\_\_\_\_\_\_\_\_ Start Date\_\_\_\_\_\_\_\_\_\_\_\_Purpose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage/Freq \_\_\_\_\_\_\_\_\_\_\_\_ Start Date\_\_\_\_\_\_\_\_\_\_\_\_Purpose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family**

With whom does your child live: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there custody and/or visitation orders in place? :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List first names and ages of your child’s brothers & sisters:

Name Age Relationship (biological, step, half, etc.) Lives with:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Past Mental health Treatment

Day Treatment:☐ Yes ☐No, If yes where and when?

Inpatient Hospitalization:☐ Yes ☐No, If yes where and when?

Outpatient Therapy:☐ Yes ☐No, If yes where and when?

Residential Treatment:☐ Yes ☐No, If yes where and when?

Describe any important medical history, chronic ailments, allergies, or other health problems your child experiences (if yes to allergies please list allergens)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Mental Health. Does anyone in the family have a history of mental health issues such as depression, anxiety, PTSD, chemical dependency suicide attempts etc. Please describe and note paternal or maternal family. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Developmental History**

Complication during pregnancy, labor or delivery? **?**☐ Yes ☐ No   If yes, please explain.

Significant stress or trauma during pregnancy? **?**☐ Yes ☐ No   If yes, please explain.

Use of prescription or non prescription drugs, tobacco or alcohol during pregnancy? **?**☐ Yes ☐ No   If yes, please explain.

**SCHOOL HISTORY**

Special Education? Do they have an IEP\_\_\_\_ Yes \_\_\_\_ No 504 Plan \_\_\_\_Yes \_\_\_\_No What grade is your child in? \_\_\_\_\_\_\_

**Current Functioning**

Please check any of the following that apply to your child:

\_\_\_\_\_\_\_\_ Difficulty transitioning from one activity to the next

\_\_\_\_\_\_\_\_ Difficulty seeing grays/ instead is a literal black and white thinker

\_\_\_\_\_\_\_\_ Impulsive, does things without thinking

\_\_\_\_\_\_\_\_ Difficulty empathizing with other or appreciating another person’s point of view or perspective

\_\_\_\_\_\_\_\_Difficulty handling changes in routines or things that are unpredictable.

\_\_\_\_\_\_\_\_ Low energy

\_\_\_\_\_\_\_\_ Isolates from family and friends

\_\_\_\_\_\_\_\_ Often worries that bad things are going to happen

\_\_\_\_\_\_\_\_ Difficulty generating solutions to problems, or uses the same solution over and over even when it doesn’t work

\_\_\_\_\_\_\_\_Easily frustrated

\_\_\_\_\_\_\_\_Chronically irritable

\_\_\_\_\_\_\_\_Difficulty persisting when things become challenging, gives up easily

\_\_\_\_\_\_\_\_ Overreacts to minor events

\_\_\_\_\_\_\_\_ Difficulty initiating interaction/conversations with peers or entering in a group of friends

\_\_\_\_\_\_\_\_ Difficulty having reciprocal conversations

\_\_\_\_\_\_\_\_Has self- injured such as cutting or burning self

\_\_\_\_\_\_\_ Very hard on themselves when they make a mistake or do something wrong

\_\_\_\_\_\_\_ Overly sensitive to textures, tastes, sounds and touch

\_\_\_\_\_\_\_ Difficulty organizing, completing and turning in homework

\_\_\_\_\_\_\_Difficulty trusting others

\_\_\_\_\_\_\_ Nightmares

\_\_\_\_\_\_\_ Hopeless, doesn’t feel like things will get better

\_\_\_\_\_\_\_ extremely shy in new situations

Who is in your and your child’s support network?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Hobbies Interests, preferred activities?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much of physical activity do they get? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How much time does your child play on the computer, watch TV, or play video games?Are they exposed to violent media or media with sexual content?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list your therapy goals for your child:

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