

Elizabeth D. Winkler, L.M.F.T.
Licensed Marriage Family Therapist #MFC44979

324 S. Beverly Drive, Suite 923
Beverly Hills, CA 90212
Tel: (310)463-2444

Child Client Information Form

(please complete both sides)

Name of Child _____

Address _____

Birth date _____ Age _____ Religious Affiliation of the child _____

School & Grade _____

Custody Status (if applicable) _____

Who referred you? _____ May we contact this person? _____

In case of an emergency, contact...

Name _____ Relationship to child _____ Phone _____

Can a message be left on answering machines? ___yes ___no

Family Members: *(please list everyone living with the client.)*

Name	Birthdate	Relationship to child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Mother's Information

Name _____ Date of Birth _____

I am: ___Biological mother ___Stepmother ___Adopted mother ___Other: _____

Address _____

Home phone _____ Cell Phone _____ Email Address _____

Can a message be left at any or all of the numbers? Home _____ Cell _____

Marital Status: ___Married ___Remarried ___Single Parent ___Widow ___Divorced ___Separated

Father's Information

Name _____ Date of Birth _____

I am: _____ Biological father _____ Stepfather _____ Adopted father _____ Other: _____

Address _____

Home phone _____ Cell Phone _____ Email Address _____

Can a message be left at any or all of the numbers? Home _____ Cell _____

Marital Status: ___ Married ___ Remarried ___ Single Parent ___ Widower ___ Divorced ___ Separated

Symptoms & Concerns

Please check any that apply to your child and circle those that are the most significant.

- | | | |
|--|--|---|
| <input type="checkbox"/> Adjustments (changing schools, pet died, parents divorce or marriage, new sibling etc.) | <input type="checkbox"/> Health concerns (physical symptoms) | <input type="checkbox"/> Anxiety/worry |
| <input type="checkbox"/> Learning difficulties | <input type="checkbox"/> Sleeping difficulties | <input type="checkbox"/> Sadness/Depression |
| <input type="checkbox"/> ADHD symptoms | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Obsessive/Compulsive |
| <input type="checkbox"/> School problems | <input type="checkbox"/> Eating Problem | <input type="checkbox"/> Mood changes |
| <input type="checkbox"/> Peer/social problems | <input type="checkbox"/> Physical disability | <input type="checkbox"/> Defiance |
| <input type="checkbox"/> Parent-child relationship problem | <input type="checkbox"/> Chronic illness | <input type="checkbox"/> Lying |
| <input type="checkbox"/> Non-family relationship problem | <input type="checkbox"/> Terminal illness | <input type="checkbox"/> Anger/irritability |
| <input type="checkbox"/> Abuse or assault victim | <input type="checkbox"/> Trauma | <input type="checkbox"/> Addiction |
| <input type="checkbox"/> Difficulty separating/dependent | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Suicidal thinking |
| | <input type="checkbox"/> encopresis/enuresis(elimination problems) | <input type="checkbox"/> Aggression/violence |

Please describe any of the above in more detail or other concerns regarding your child _____

If your child has ever seen a mental health professional (psychiatrist, psychologist, or counselor), please list when, who, and why they were seen.

Is your child currently taking any medications? If yes, please list and explain _____

Primary Care Physician Name, phone number: _____

Signatures: I certify that the information provided above is accurate to the best of my knowledge. If any of the information changes, I will provide updated information to Elizabeth D Winkler, MFT as soon as possible.

Mother's Signature

Date

Father's Signature

Date

Child's Signature

Dat