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

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