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Personal Data Form-Child

I. Background Information

Person filling out form: _____ Today's Date: _____

Child's Information:

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Gender: (circle) Male/Female

School: _____ Grade: _____ Special ed: _____ TAG: _____

Parent (s) Primary Caretaker(s)/Legal Guardian:

Mother's Name: _____ Age: _____ DOB: _____

Occupation: _____

Father's Name: _____ Age: _____ DOB: _____

Occupation: _____

If you are divorced, who has decision making responsibility?

Mother sole decision making: _____ Father sole decision making: _____

Joint decision making: _____ Other: (one parent can make decisions on certain issues)

(Please explain) Please provide court documentation supporting decision making responsibility. If you are bringing in the child for therapy, is the other parent willing to be involved in therapy, and/or willing to sign a consent to treatment form, if the minor child is younger than 15?

Yes ___ No ___ Please explain if no? _____

Please be aware if both parents have joint decision making responsibility, I will need to have the consent of both parents to proceed with treatment of your child.

Home address

Street Address: _____ City: _____

State: _____ Zip Code: _____

Phone Numbers:

Cell: _____ Home/Evening: _____ Work: _____

Email Address: _____ 2nd Email Address: _____

Home Address of other parent (if applicable):

Street Address: _____ City: _____

State: _____ Zip Code: _____

Phone Numbers:

Cell: _____ Home/Evening: _____ Work: _____

Email Address: _____ 2nd Email Address: _____

How did you hear about me? I would like to contact this person to thank them for the referral. If this is ok, please list their name: _____

II. Insurance Information

Do you have insurance? Yes _____ No _____

Name of Insurance Company: _____ ID#: _____

Group #: _____
 Insurer's Name: _____ Insurer's DOB: _____
 Insurer's Address: _____
 Insurer's Social Security #: _____ Insurer's Employer: _____
 Co-payment per session: _____ Annual Deductible: _____

Please fill out accurately, to ensure insurance will pay for services. Thank-you.

Current Employer:

Employer: _____
 Address: _____
 Work #: _____

III. Name and Ages of Children (please include stepchildren)

Name of Child	Age: DOB	Relationship you have with the child (close, +,-, estranged)	Child from a previous relationship or marriage?

If there is a stepparent or significant other involved with your child, what type of relationship do they have?

Is your spouse or significant other willing to participate in therapy if needed? Yes ___ No ___

IV. Present Problem(s)/Concern(s)

Why are you seeking psychotherapy for your child?

What is your goal(s) for your child during this period of treatment?

Does your child have any pending legal charges? Yes _____ No _____ If yes, please explain below:

Is your child being seen by a psychiatrist? Yes ___ No _____

Name of psychiatrist: _____

Psychiatrist's Phone Number: _____

A signed release is required for any communication between myself and outside providers.

Psychotherapy History:

Please list any previous mental health services including hospitalization below:

Therapist/Doctor	Dates	Reason for treatment

Please any medication your child is taking:

Name of medication	Dosage	Prescribed by whom?

Has your child ever made a suicide attempt? If yes, please explain, describe circumstances, how and when?

Has anyone in your family had psychological or psychiatric problems? If yes, please explain:

Has anyone in your family had alcohol or drug problems? If yes, please explain:

V. Medical History

Please list any current medical problems for your child:

Please list any medical problems that you as the parent/your spouse/ex/ significant other have, that may interfere with your parenting?

For Teens:

Pregnant now: Yes _____ No _____ Unsure: _____

Abortions: Yes _____ No _____

VI. Social History

What are your child's strengths? (please list 3)

Weaknesses:

Does your child have friends? Please elaborate:

Are there any recent changes in your child's life that I should be aware of? Please explain:

Please check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Divorce | <input type="checkbox"/> School failure |
| <input type="checkbox"/> New Siblings | <input type="checkbox"/> Relationship loss |
| <input type="checkbox"/> New stepsisters/brothers | <input type="checkbox"/> Learning disability identification |
| <input type="checkbox"/> New family members in the home | <input type="checkbox"/> Drug/alcohol use |
| <input type="checkbox"/> Recent move/relocation | <input type="checkbox"/> Death of a family member |
| <input type="checkbox"/> Death of a parent | <input type="checkbox"/> Natural disaster exposure |
| <input type="checkbox"/> Ostracized by friends | <input type="checkbox"/> Sports/extra-curricular failure |
| <input type="checkbox"/> Parent's work schedule changed | <input type="checkbox"/> Significant fighting/discord in home |

Treatment Goals for your child in therapy:

1. _____
2. _____
3. _____

VII. Parenting/Family Environment

Describe your relationship with your child, your strengths and weaknesses as a parent:

Describe your spouse's/other parent's relationship with your child, his/her strengths and weaknesses as a parent:

Describe your parenting style with your child: (lenient, strict,structured, unstructured, consistent, inconsistent, level of involvement in discipline)

Spouse's/other parent's parenting style:

Parenting challenges with the child?

Discipline techniques/consequences used with the child?

Areas of support you would like with your parenting?

Signature of parent/guardian

Date