Monica Ramunda, MA, LPC ,RPT

(720)304-7611

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 every 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?

____

____

<u>For Teens</u>:
Pregnant now: Yes _______ No_______ Unsure: _______
Abortions: Yes _______ No______

<u>VI. Social History</u>

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:

____ Divorce
____ New Siblings
____ New stepsisters/brothers
____ New family members in the home
____ Recent move/relocation
____ Death of a parent
____ Ostracized by friends
____ Parent's work schedule changed
____ School failure
____ Relationship loss
____ Learning disability identification
____ Drug/alcohol use
____ Death of a family member
____ Natural disaster exposure
____ Sports/extra-curricular failure
____ 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