Healing Hearts Therapy
2751 Buford Hwy NE, Suite 402
Atlanta, Georgia 30324

CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _____

Your child's name: _____
Last First Middle Initial

Parent or Legal Guardian's Name: _____
Last First Middle Initial

Child's date of birth: _____ **Gender:** _____
Home street address: _____
City: _____ **State:** _____ **Zip:** _____
Parent or Legal Guardian's Name of Employer: _____
Address of Employer: _____
City: _____ **State:** _____ **Zip:** _____
Home Phone: _____ **Work Phone:** _____
Cell Phone: _____ **Email:** _____
Calls will be discreet, but please indicate any restrictions: _____
_____

Referred by: _____

- May I have your permission to thank this person for the referral?
  - **Yes • No**
- If referred by another clinician, would you like for us to communicate with one another?
  - **Yes • No**

Person(s) to notify in case of any emergency: _____ _____
Name Phone

We will only contact this person if we believe it is a life or death emergency. Please provide your signature to indicate that we may do so: (Your Signature): _____

Please briefly describe your child's presenting concern(s): _____
_____
_____

What are your/your child's goals for therapy? _____
_____
_____

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MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses your child has had:_____

_____

_____

_____

Current Medications (if you need more room, please write on the back of this page):

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous medical hospitalizations (Approximate dates and reasons): _____

_____

_____

Previous psychiatric hospitalizations (Approximate dates and reasons): _____

_____

Has your child ever talked with a psychiatrist, psychologist, or other mental health professional? (If yes, please list approximate dates and reasons): _____

_____

_____

FAMILY:

How would you describe your child's relationship with his or her mother?_____

_____

_____

How would you describe your child's relationship with his or her father?_____

_____

_____

Are the child's parents still married or did they divorce?_____If divorced, what is the custody arrangement (hard copy of custody paperwork is required at the time of intake) _____

_____

Please describe your child's relationship with his or her grandparents: _____

_____

_____

Were there any other primary care givers who have had a significant relationship with your child? If so, please describe how these people may have impacted your child's life: _____

_____

_____

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How many siblings does your child have? _____Ages? _____

How would you describe your child's relationships with his or her siblings?_____

_____

_____

_____

SOCIAL SUPPORT, SELF-CARE, & EDUCATION: POOR EXCELLENT

Child's current level of satisfaction with friends and social support: 1 2 3 4 5 6 7

How would you describe your child's relationships with his/her peers? _____

_____

Please briefly describe any history of abuse, neglect and/or trauma: _____

_____

_____

Please briefly describe your child's self-care and coping skills: _____

_____

_____

What are your child's diet, weight, and exercise/activity patterns?_____

_____

_____

Please briefly describe your child's school performance and experience:_____

_____

_____

What are your child's hobbies, talents, and strengths?_____

_____

_____

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PLEASE CHECK ALL THAT APPLY TO YOUR CHILD & **CIRCLE** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST
Anxiety →				Tantrums →				Nausea →		
Depression				Parents Divorced				Stomach Aches		
Mood Changes				Seizures				Fainting		
Anger or Temper				Cries Easily				Dizziness		
Panic				Problems with Friend(s)				Diarrhea		
Fears				Problems in School				Shortness of Breath		
Irritability				Fear of Strangers				Chest Pain		
Concentration				Fighting with Siblings				Lump in the Throat		
Headaches				Issues Re: Divorce				Sweating		
Loss of Memory				Sexually Acting Out				Heart Problems		
Excessive Worry				History of Child Abuse				Muscle Tension		
Wetting the Bed				History of Sexual Abuse				Bruises Easily		
Trusting Others				Domestic Violence				Allergies		
Communicating with Others				Thoughts of Hurting Someone Else				Often Makes Careless Mistakes		
Separation Anxiety				Hurting Self				Fidgets Frequently		
Alcohol/Drugs				Thoughts of Suicide				Impulsive		
Drinks Caffeine				Sleeping Too Much				Waiting His/Her Turn		
Frequent Vomiting				Sleeping Too Little				Completing Tasks		
Eating Problems				Getting to Sleep				Paying Attention		
Severe Weight Gain				Waking Too Early				Easily Distracted by Noises		
Severe Weight Loss				Nightmares				Hyperactivity		
Head Injury				Sleeping Alone				Chills or Hot Flashes		

If you have noted any physical health problems above, please list your current medical providers and date of last appointment:

_____

_____

_____

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FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems				Physical Abuse				Depression			
Legal Trouble				Sexual Abuse				Anxiety			
Domestic Violence				Hyperactivity				Psychiatric Hospitalization			
Suicide				Learning Disabilities				"Nervous Breakdown"			

Any additional information you would like to include:

_____

_____

_____