Sven Schild, Ph.D., Psychologist, Inc.
CA License #: PSY 22339
www.svenschild.com

Child Client Information

Name:__________________________ Today's Date:________________________

Date of Birth:________________ Age:_________ SS#______________________

Parent's Home Phone:________________
Parent's Work Phone:________________

Parent's Email:________________________
Child's Email:_________________________

Home Address:____

City, State, Zip Code:____

Parents Married/Single/Divorced/Separated? How long:_____________

Names, Ages and Dates of Birth of Children:____
____
____

If divorced or separated, is your ex-partner remarried or in a relationship?____________________
If yes, are there any other children involved in that relationship?___________________________
____
____

Name of partner/spouse:________________________ Date of Birth:__________

SS#________________________ Occupation______________________________

Employer___________________________ Work#__________________________

Work Address____

Do you have Medical Insurance: Yes_____ No_____ Name of insurance: _________________

Insurance Address:____

Insurance Phone #_________________ Name of person insured:______________
Insured's Soc. Sec. #____________________________

Do you have MediCal? Yes____ No____ MediCal #:____________________

Do you have Medicare? Yes___ No___ Medicare #:____________________

Who referred you:_______________________ Relationship:________________

Emergency contact information:_______________________________________

Relationship:_____________________ Phone #:_________________________

Who is your child's Primary Care Physician or Pediatrician?
____

Phone#:__________________________ Address:________________________

Does your child have any medical conditions or allergies? _______________________________
____
____

Is your child taking any medications? _____ yes _____no.
If yes, please list medication and dosage:____
____
____
Prescribed by: __________________________ Phone #:________________________________

Are you or your child court-ordered to attend therapy? Yes_____ No______

If yes, who ordered you to attend therapy?: Probation:____ Social Worker_____

Name of Social Worker/Probation Officer:____

Address:____

Phone #___________________ Email:____

Prior counseling, therapy or drug treatment (include dates, therapist/program and why you or your child/family went to counseling or treatment:_________________________
____
____

Please explain why you want counseling and how we might help you:______________________

____

____

Has your child/teen ever used drugs or alcohol? Yes:_____ No:______ If yes, please indicate which drugs and how often:____

____

____

Does anyone in your family have a drinking or drug problem? ____Yes ____No
If yes, please explain:____

____

____

What does your child/teen enjoy doing for fun?:______________________________________

____

____

What are your child or teen's strengths?____

____

____

What areas of your child's or teen's life are you presently worried about? Please check all that apply:

School academic performance/grades ____
School absences or truancy ____
Attitude at school ____
Negative peer influence ____
Difficulty making/keeping friends ____
Isolates him or herself at home ____
Seems sad or depressed most of the time ____
Seems anxious or worried most of the time ____
Has trouble staying on task and focusing ____
Homework is a struggle ____
Poor communication with parents ____
Constant fighting with siblings ____
Doesn't make friends easily ____
Concerns about drugs or drinking ____

Are there any other concerns you have at this time regarding your child or teen's behavior or emotional health? ____Yes ____No. If yes, please explain:_______________________________

____

____