

TRAUMA RESEARCH INSTITUTE

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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 #:_____

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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 #:_____

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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: _____

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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: _____
