Sabine Boots, M.S., LMFT
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Child Information

Child's name: _____ Date of Birth: _____ School Grade: ____

Siblings: _____ DOB: _____ School Grade: ____

_____ DOB: _____ School Grade: ____

Name of Parent: _____ DOB: _____

Profession: _____

Spouse/Partner: _____ DOB: _____

Profession: _____

Mailing address:

_____

Phone number home: _____ Cell: _____

E-mail address: _____

Is it OK to contact you via e-mail? Please initial: Yes _____, No _____ (due to the nature of the Internet safeguarding of information cannot be guaranteed by the therapist)

Referring source (physician/other): _____

Has your child ever seen a psychologist ____, counselor ____, psychiatrist ____, or been admitted to a psychiatric hospital _____? If yes, for what:

_____

Is your child currently taking any medications? If yes, which:

_____

Did your child develop any health problems that required medical intervention of hospital stay?

Such as: Pneumonia ____	Ear Infection ____	Jaundice ____
Sore throat ____	Scarlet Fever____	Whooping Cough ____
Meningitis____	Rheumatic Fever____	Seizure ____
High Fever____	Surgery ____	Other ____

Did your child stutter or receive speech therapy? _____

Did your child ever stop talking once started or lose skills? _____

Has the child ever had an accident, fall or blow to the head/body? _____

If yes to any of the above questions, indicate age and duration _____

What are your child's sleep patterns?

Regular ____ interrupted sleep ____ difficulties going to sleep____

sleep walking ____ Asleep during the day ____ nightmares/terrors ____

difficult to wake up ___ My child sleeps _____ hours a night

Are you worried about your child's eating habits?

If yes, please explain:

_____

What are your main concerns about your child at this time?

_____

_____

_____

Please, answer following questions using the numbers 1-5:
1=never, 2=rarely, 3=sometimes, 4=frequently, 5=almost always

1. My child seems to feel stressed at school. _____
2. My child has difficulties making or keeping friends. _____
3. My child lacks concentration. _____
4. My child is easily irritated. _____
5. My child has bowel problems, such as constipation, diarrhea, and/or Stomach cramps. _____
6. My child complains of headaches. _____
7. My child does not participate in activities that were previously enjoyable. _____
8. My child seems to lack self-esteem. _____
9. My child has bed-wetting problems. _____
10. My child is "hyper" or "busy" _____

Please have all legal guardians' sign that you are allowing Sabine Boots, LMFT to treat your child In individual psychotherapy and/or family therapy. If I see your child separately, I will update you on his/her progress and advise you in how to integrate the therapeutic gain into your family.

_____

Signature guardian 1 Date

_____

Signature guardian 2 Date