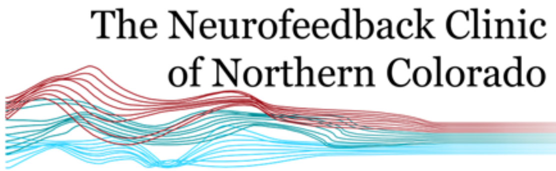

Neurofeedback Clinic of Northern Colorado
4115 Boardwalk Drive, Ste 100
Fort Collins, CO 80525
P970-493-4580

CHILD INFORMATION FORM

Name____ Date of 1st Appointment____________ Therapist _________________________

Date of Birth ______________________ Age _______ Gender: Male ________ Female ________

MEDICAL HISTORY

Name of Primary Care Physician: ____

Physician's Address:____Physician's Phone:_____________________________________

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Check One) YES NO

Please sign here for either answer:____

Date of last medical evaluation:______________________________ Date of next appointment:__________________________________

Current medications being taken:

1)____________________________ Dosage/Freq ____________ Start Date____________ Purpose_____________________________________

2)____________________________ Dosage/Freq ____________ Start Date____________ Purpose_____________________________________

3)____________________________ Dosage/Freq ____________ Start Date____________ Purpose_____________________________________

4)____________________________ Dosage/Freq ____________ Start Date____________ Purpose_____________________________________

Prescribed by: ____

Has your child ever been hospitalized for medical or psychiatric reasons? (Check one) YES NO

Hospital	Mo/Yr	Reason
____	___________	____
____	___________	____
____	___________	____

Does your child have allergies? (Check one) YES NO

Does your child have asthma? (Check one) YES NO

Describe any important medical history, chronic ailments, or other health problems your child experiences:

____

____

____

Describe any other health problems or important medical history about your child's immediate family members and close relatives, including chronic ailments: ____

____

____

Does your child have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: ____

____

____

SCHOOL HISTORY

Does your child experience any developmental, academic or behavior problems while in school or daycare, with peers or teachers?

______YES ______NO If yes, please explain:____

____

What was the last year of school your child completed? _______

What school is he/she attending? ______________________________ Is your child home-schooled? (Check One) YES NO

Please check all information which applies to your child's biological parents:

MOTHER
____ living
____ deceased
____ married
____ divorced
____ remarried ____# of times

FATHER
____ living
____ deceased
____ married
____ divorced
____ remarried ____# of times

With whom does your child live: ____

What custody and/or visitation orders are in place? :____

*** Please copy orders to be placed in client's file.**

Does your child consider anyone else to be a "parent" in his/her life? YES NO If so, whom?_ ________________________________

Describe your relationship with your child:

Currently: ____

____

In the past: ____

____

Describe your child's relationship with his/her other parent:

Currently: ____

____

In the past: ____

____

List first names and ages of your child's brothers & sisters:

Name	Age	Relationship (biological, step, half, etc.)	Lives with:
________________________	_____	________________________	________________
________________________	_____	________________________	________________
________________________	_____	________________________	________________
________________________	_____	________________________	________________

Describe any problems which occurred in your child's family relating to:

Alcohol/drug abuse: ____

____

Sexual/physical/emotional abuse:____

____

Others living in the home with your child:

Name	Age	Relationship	Grade/Occupation
________________________	____	________________	________________________
________________________	____	________________	________________________
________________________	____	________________	________________________
________________________	____	________________	________________________

MENTAL STATUS

Please check any of the following that describe how you believe your child has been feeling lately:

____sad ____anxious ____depressed ____frightened ____guilty ____angry ____ashamed ____aggressive ___resentful

____worthless ___tearful ____irritable ____confused _____extreme ups/downs _____jealous _____hopeless ___helpless

Describe any behaviors your child has demonstrated that cause concern: ____

____

Has your child had any change in sleeping habits? (Check One) YES NO Describe: ___________________________________

____

Has your child had any change in eating habits? (Check One) YES NO

Describe:____

____

Has your child ever considered suicide in connection with his/her **current** problem? (Check One) YES NO

If so, please give a brief description with dates:____

Has your child ever **considered suicide** in the **past**? (Check One) YES NO

Has your child **attempted suicide recently** or in the **past**? (Check One) YES NO

If so, please give a brief description with dates: ____

____

Has your child tried to hurt others or animals recently or in the past? (Check One) YES NO
If yes, please explain: ____

____

LEVEL OF FUNCTIONING

Please describe what activities your child participates in:____

____

Who is in your child's support network? ____

____

Please describe your child's level of physical activity: ____

____

How much time does your child play on the computer, watch TV, or play video games: ______________________________

____

Please select any of the following concerns that your child or your family may be experiencing:

Nervousness	Toileting	Suicidal Thoughts	Nightmares
Shyness	Depression	Finances	Behavioral Problems
Separation/Divorce	Sexual Problems	Unhappiness	Temper
Drug Use	Alcohol	Work	Death of a Loved One
Anger	Self-Control	Tiredness	Appetite/Eating
Sleep	Stress	Ambition	Parenting
Relaxation	Headaches	Decision Making	Stomach Trouble
Legal Matters	Memory	Concentration	Marital Problems
Energy	Insomnia	Health Problems	
Loneliness	Feeling Inferior	Education/School	

Is there any other information regarding your child that you would like to share with your child's Therapist that is not covered on this form? You may also use this space to complete earlier responses.

____

____

____

____

Please list your therapy goals for your child:

____

____

____

____

THANK YOU!