LifePaths Counseling Center
6901 S. Pierce St., Suite 350
Littleton, CO 80128
(303) 801-7878

Confidential Child Client Information Summary

Child's Name:_____ **Birthdate:**_____ **Age:**_____

School:_____ **Grade:**____ **Teacher:**_____ **Counselor:**_____

Parent/Guardian:_____ **Parent/Guardian**_____

Address:_____ **Address:**_____

City:_____ **Zip Code:**_____ **City:**_____ **Zip Code:**_____

Preferred Phone:_____ **Msg ok?**__ **Preferred Phone:**_____ **Msg. ok?**___

Email address:_____ **Msg ok?**__ **Email Address:**_____ **Msg. ok?**___

Does anyone else have access to your e-mail address? □ **Yes** □ **No**

Marital Status of child's parents/guardians:(Please include the timing of any death/divorce/separation or union)_____

_____

Living Arrangement

□ **Parents** □ **One Parent** □ **Different according to time** □ **Guardian**

Pertinent details:_____

Please list all family members or other people living in the child's home:

Name	Age	Gender	Relationship to child

Please list all other family or important people in your child's life:

Name Age Gender Relationship to Child Other Information

_____

_____

_____

_____

_____

_____

Medical Information:

Current Medical Conditions:_____

Medications or Treatments:_____

Physician Name:_____City:_____Phone:_____

EMERGENCY CONTACTS (please list name and phone numbers)

(1) _____

(2) _____

Has your child been in therapy before? No ____ Yes _____

Therapist's Name(s) Dates Reason for Therapy Outcome

_____

_____

_____

Have other family members been in therapy before? No _____ Yes _____

Therapist's Name(s) Dates Reason for Therapy Outcome

_____

_____

_____

Please describe reason(s) for seeking therapy at this time:

_____

Please circle any of the following that pertain to your child:

Nervousness	Depression/Sadness	Angry/Aggressive	School Problems	Eating Difficulties
Shyness	Cries Easily	Self-Control	Drug/Alcohol Use	Head/Stomach Aches
Loneliness	Feeling Inferior	Difficult to Discipline	Legal Problems	Sleep Difficulties
Fears	Fatigue	Difficulty with friends	Attention/Memory	Nightmares
Separation	Loss of Interest	Suicidal Thoughts	Difficulty Relaxing	Troubling Thoughts

Please list major changes your child and/or family have experienced during the past five years:

(e.g. death (people or pets), moves, health changes, family changes, stress, trauma, school or job changes)

Current Family Substance Use: (Include alcohol, marijuana, nicotine, prescription and non-prescription drugs)

Other Information:

Parent/Guardian Signature

Date