HartsSpace
Mental Health & Nutrition

Child Information

Date: _____

A. Identification Information

Name: _____ DOB: _____ SSN: _____

Address: _____ Phone (Home): _____

City: _____ State: _____ Zip: _____ Phone (cell) _____

School child attends: _____ Grade _____

School Telephone: _____

Custodial parent(s) or legal guardian(s) name and phone numbers:

_____

_____

_____

B. Family Information

Number of siblings, their names and ages_____

_____

How does your child get along with siblings? _____

Does your child make and keep friends? _____

Child is currently living with

☐ biological mother ☐ biological father
☐ step-mother ☐ step-father
☐ foster mother ☐ foster father
☐ other _____

Family History of:

☐ Depression ☐ Suicide Attempts ☐ Anxiety
☐ Eating Disorders ☐ Mental Illness ☐ Violence
☐ Sexual Abuse ☐ Emotional Abuse ☐ Alcoholism/Drug Addiction
☐ Chronic Illness (please explain) _____
☐ Other _____

_____

C. Medical Information

Pediatrician/Family Physician: _____

Phone: _____ Last Exam: _____

Major (or Chronic) Operations/Illnesses/Injuries _____

_____

_____

Current Medications Dosage(s) Frequency Effectiveness Prescribing Physician

_____

_____

_____

Has your child experienced any recent changes in:

☐ Sleep ☐ Nightmares ☐ Mood ☐ Anxiety ☐ Eating/Appetite ☐ Weight ☐ Energy level

How would you characterize your child's overall health?

☐ Poor ☐ Fair ☐ Good ☐ Excellent

Does your child have any food allergies?_____

D. Other

Is there anything else I should know about your child prior to beginning treatment?

_____

_____

_____

_____

_____