Robert L. Kaufman, Ph.D.

Clinical Psychology • Neuropsychology • Forensic Consultation

CLIENT INFORMATION FOR CHILD ASSESSMENT

NAME OF CHILD:______________________________ **TODAY'S DATE:**______________________

AGE:_______________ **SEX:** ____________________ **BIRTHDATE:**__________________________

PLEASE LIST CONTACT INFORMATION FOR EACH PARENT, INCLUDING ALL ADDRESSES IF PARENTS DO NOTLIVE TOGETHER

NAME OF PARENT:

____

HOME ADDRESS:____

____

HOME PHONE:_________________________ **BUSINESS PHONE:**___________________

EMAIL: _________________________________ **CELL PHONE:** _________________________

OCCUPATION:_________________________ **EMPLOYER**____________________________

NAME OF PARENT:

____

HOME ADDRESS:____

____

HOME PHONE:_________________________ **BUSINESS PHONE:**___________________

EMAIL: _________________________________ **CELL PHONE:** _________________________

OCCUPATION:_________________________ **EMPLOYER**____________________________

PARENTS' MARITAL STATUS:____

DATE(S) OF MARRIAGE(S):____

DATE(S) OF DIVORCES(S):____

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HAS YOUR CHILD SEEN A PSYCHOLOGIST OR THERAPIST BEFORE? ☐ **Yes** ☐ **No**

IF SO, NAME(S) OF PREVIOUS THERAPIST(S) & DATE(S) OF TREATMENT OR EVALUATION:

____

____

DOES YOUR CHILD SUFFER FROM ANY SERIOUS MEDICAL CONDITIONS? ☐ **Yes** ☐ **No**

IF SO, PLEASE LIST:____

CURRENT MEDICATIONS: ____

CHILD'S PEDIATRICIAN:____

LIST FAMILY MEMBERS AND OTHERS LIVING IN EACH HOUSEHOLD

NAME	RELATIONSHIP TO CHILD	AGE

CHILDREN LIVING AWAY FROM HOME

____

____

IF PARENTS ARE CURRENTLY INVOLVED IN A LEGAL PROCEEDING RELATED TO YOUR SEEKING CONSULTATION, PLEASE PROVIDE THE NAME, ADDRESS AND PHONE NUMBER OF YOUR ATTORNEY:

____

____

IF YOU ARE BRINGING IN YOUR CHILD FOR EVALUATION OR TREATMENT, PLEASE PROVIDE THE FOLLOWING INFORMATION:

CHILD'S SCHOOL:_________________________________ **GRADE:**__________

TEACHER / OTHER SCHOOL PERSONNEL WHO KNOWS YOUR CHILD BEST:

____

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