virginia lindahl Ph.D.
Therapy and Psychological Testing

CLIENT REGISTRATION FORM - CHILD

Today's Date:	
Client Information	
Child's first name	Child's last name
Child's date of birth	Who does the child live with?
Family Information	
Parent one's first name	Parent two's last name
Address	
Home phone number	Cell phone number
Occupation	Highest level of education
Parent two's first name	Parent two's last name
Address	
Home phone number	Cell phone number
Occupation	Highest level of education
Who referred you?	

Please list all immediate family members. Please include name, relationship to child, age, location, and any mental illness.

Name	Relationship	Age	Location	Mental Illness

Medical History

Is your child currently taking medication?

Yes
No

If yes, please list current medication names, dosages, and reason for taking.

Please list any significant medical history, including chronic conditions, accident, major illnesses, surgeries, etc.).

Please list any psychiatric diagnoses your child has received in the past, including who diagnosed the child and when.

Please list any psychiatric treatment your child has received in the past, including psychotherapy and hospitalizations. Include reasons, locations, and timeframe.

Reasons for Seeking Treatment

Why are you seeking therapy now?

Describe your goals for therapy.

Is there any other information that you think would be helpful in working with your child?