Kyle Jankowski, M. MFT, LMFT
(830) 708-4919

Child/Adolescent Client Information Form

Form Completed by: _____ Today's date: _____

A. Identification:

Child/Adolescent's name: _____ Date of birth: _____ Age: ___

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

B. Chief Concern: Please describe the main difficulty that has brought you to therapy.

_____

_____

_____

_____

C. Referral: How did you hear about Kyle Jankowski, LMFT? _____

D. Child/Adolescent's Race/Ethnicity:

_____

E. Information about Child/Adolescent:

What are this child's strengths?

_____

What are this child's favorite activities?

_____

What are this child's favorite toys or possessions?

_____

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What are this child's favorite books, TV shows, and movies?

_____

How is this child disciplined by caregivers/parents, and for what reasons?

_____

F. Daycare or School Information:

Which school does this child/adolescent attend? _____Grade: ____

Describe child's academic, social, and behavioral evaluations by school personnel over the past year.

_____

_____

Child's Grades (circle all that apply if applicable): A's B's C's D's F's

Child's School Conduct Ratings (if applicable): N S E

Comments: _____

_____

G. Child/Adolescent's Medical Information:

From whom or where does this child get medical care?

_____

Clinic/doctor's name: _____

Please list any medical issues your child may have: _____

_____

Does your Child have any Hearing issues? ☐ Yes ☐ No

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Please list all medications or drugs taken by this child in the last year—prescribed, or over-the-counter. _____

_____

Medication/ Drug Dose Taken for: (how much?) _____

_____

Prescribed and supervised by: _____

_____

Has this child ever attended counseling or therapy before? If yes, describe when, where, and for what condition: _____

_____

Was this a helpful experience? ☐ Yes ☐ No

H. Other adults significantly involved in the care of this child/adolescent?

_____

_____

I. Legal or Other Involvement:

Is this child required by a court, a probation officer, or school official to seek counseling at this time? ☐ Yes ☐ No
If so, please describe:_____

_____

Is anyone in this child's family currently / recently involved in any court proceedings?
☐ Yes ☐ No
If so, please describe:_____

_____

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J. Other Children in Family (list all full-, half-, or step-siblings, even if they do not reside in the same home; Please be prepared to provide documentation that you have legal authority to consent for the treatment of any minors attending therapy.)

Name	Current age	Gender	Childcare or School Attending
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____
5._____	_____	_____	_____

K. Parent/Guardian Information:

MOTHER/CAREGIVER (Check one: ☐ Birth parent ☐ Adoptive parent ☐ Step-parent

☐ Other_____) Name :_____

Date of Birth: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Will be participating in therapy process? ☐ Yes ☐ Unsure ☐ No
Home/evening phone: _____ May I call her at home? ☐ Yes ☐ No
May I leave a message for her at home? ☐ Yes ☐ No Any restrictions? _____

Employer:_____Address:_____

_____

Work phone:_____ May I call her at work? ☐ Yes ☐ No
May I leave a message for her at work? ☐ Yes ☐ No Any restrictions? _____

Cell phone: _____ May I leave a message on cell phone? ☐ Yes ☐ No

Email address: _____

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Check all that apply:

☐ No legal actions have impacted parental rights/duties.
☐ Individual is a Joint Managing Conservator for this child with legal rights and duties articulated in legal document, such as a divorce decree*.
☐ Individual is a Sole Managing Conservator with exclusive legal rights and duties articulated in a legal document, such as a divorce decree*.
☐ Individual is aware of engagement of therapeutic services for this child. □Individual is in agreement with engagement of therapeutic services for this child.

FATHER/CAREGIVER (Check one: ☐ Birth parent ☐ Adoptive parent ☐ Step-parent

☐ Other_____) Name :_____

Date of Birth: _____

☐ Check here if father and mother live at same address (then only complete phone numbers):

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____
Will be participating in therapy process? ☐ Yes ☐ Unsure ☐ No
Home/evening phone: _____ May I call him at home? ☐ Yes ☐ No
Does he have an answering machine on the phone? ☐ Yes ☐ No
May I leave a message for him at home? ☐ Yes ☐ No Any restrictions? _____

Employer:_____

Address:_____

Work phone:_____ May I call him at work? ☐ Yes ☐ No
May I leave a message for him at work? ☐ Yes ☐ No Any restrictions? _____

Cell phone: _____May I leave a message on the cell phone? ☐ Yes ☐ No

Email address: _____

Check all that apply:

☐ No legal actions have impacted parental rights/duties.
☐ Individual is a Joint Managing Conservator for this child with legal rights and duties articulated in legal document, such as a divorce decree*.
☐ Individual is a Sole Managing Conservator with exclusive legal rights and duties articulated in a legal document, such as a divorce decree*.
☐ Individual is aware of engagement of therapeutic services for this child. □Individual is in agreement with engagement of therapeutic services for this child.

*Please provide a copy of any legal document impacting guardianship/conservatorship and rights/duties related to psychological and mental health care.

Please use this remaining space for any other information you believe I need to know about your child, family, or circumstances.

_____