

**EMU Psychology Clinic**  
**611 W. Cross Street**  
**Ypsilanti, MI 48197**  
**(734) 487-4987**

**Client Application – Child**

**A. Identification**

1. **Child's name** \_\_\_\_\_  
Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Grade: \_\_\_\_\_  
Race/ethnicity: \_\_\_\_\_ Religious affiliation: \_\_\_\_\_  
Social security number or other unique identifier (PIN): \_\_\_\_\_  
Person(s) completing this form \_\_\_\_\_ Today's date \_\_\_\_\_  
How did you learn about the services provided at the EMU Psychology Clinic: \_\_\_\_\_  
\_\_\_\_\_

Child's custodian/guardian(s) is/are: \_\_\_\_\_  
Child's Home Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Telephone \_\_\_\_\_ Other Phone (specify type) \_\_\_\_\_  
Is it OK to contact you/child at home? \_\_\_\_\_ OK to leave a message? \_\_\_\_\_  
Special instructions? \_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_ **Relationship to Child:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Telephone \_\_\_\_\_ Other Phone (specify type) \_\_\_\_\_

2. **Mother's name** \_\_\_\_\_ **Birthdate** \_\_\_\_\_ **Home phone:** \_\_\_\_\_  
**Address** \_\_\_\_\_  
**Race/ethnicity:** \_\_\_\_\_ **Religious affiliation:** \_\_\_\_\_  
**Highest Grade Completed:** \_\_\_\_\_  
**Marital/relationship status (Check one)**  
 Married    Live with partner (check if same \_\_\_ or opposite \_\_\_ sex)    Single  
 Separated/Divorced;    Widowed; or    Other: \_\_\_\_\_  
**Employment status (Check all that apply):**  
 employed    retired    disabled    student    homemaker    unemployed  
If/When employed, what type of work does mother do? \_\_\_\_\_

Current employer is: \_\_\_\_\_

Years on Current Job: \_\_\_\_\_ Business Phone \_\_\_\_\_

Is it OK to contact mother at work?  yes  no

OK to leave a message?  yes  no

Special calling instructions? \_\_\_\_\_

3. **Father's** name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home phone: \_\_\_\_\_

Address \_\_\_\_\_

Race/ethnicity: \_\_\_\_\_ Religious affiliation: \_\_\_\_\_

Highest Grade Completed: \_\_\_\_\_

Marital/relationship status (Check one)

Married  Live with partner (check if same \_\_\_ or opposite \_\_\_ sex)  Single

Separated/Divorced;  Widowed; or  Other: \_\_\_\_\_

Employment status (Check all that apply):

employed  retired  disabled  student  homemaker  unemployed

If/When employed, what type of work does father do? \_\_\_\_\_

Current employer is: \_\_\_\_\_

Years on Current Job: \_\_\_\_\_ Business Phone \_\_\_\_\_

Is it OK to contact father at work?  yes  no

OK to leave a message?  yes  no

Special calling instructions? \_\_\_\_\_

4. **Step-parent's** name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home phone: \_\_\_\_\_

Address \_\_\_\_\_

Race/ethnicity: \_\_\_\_\_ Religious affiliation: \_\_\_\_\_

Highest Grade Completed: \_\_\_\_\_

Marital/relationship status (Check one)

Married  Live with partner (check if same \_\_\_ or opposite \_\_\_ sex)  Single

Separated/Divorced;  Widowed; or  Other: \_\_\_\_\_

Employment status (Check all that apply):

employed  retired  disabled  student  homemaker  unemployed

If/When employed, what type of work does step-parent do? \_\_\_\_\_

Current employer is: \_\_\_\_\_

Years on Current Job: \_\_\_\_\_ Business Phone \_\_\_\_\_

Is it OK to contact step-parent at work?  yes  no

OK to leave a message?  yes  no

Special calling instructions? \_\_\_\_\_

**B. Reason for Seeking Treatment**

Please briefly describe the problems your child is experiencing: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What has happened to cause you to seek help NOW? \_\_\_\_\_

\_\_\_\_\_

What do you hope to be able to do or achieve as a result of treatment? \_\_\_\_\_

\_\_\_\_\_

What do you consider to be other stresses in your child's life? \_\_\_\_\_

\_\_\_\_\_

**C. History of the Problem**

When did your child first start experiencing the problem(s) that brought you to the clinic today? \_\_\_\_\_

\_\_\_\_\_

How often does the problem occur? \_\_\_\_\_

How long does it last? \_\_\_\_\_

Does your child have any thoughts of harming him/herself? No \_\_\_\_\_ Yes \_\_\_\_\_

Has your child ever attempted to harm him/herself? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, please explain:

\_\_\_\_\_

Does your child have any thoughts of harming someone else? No \_\_\_\_\_ Yes \_\_\_\_\_

Has your child ever attempted to harm someone else? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, please

explain: \_\_\_\_\_

Has your child ever had previous therapy/counseling of any kind? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, when and for how long? \_\_\_\_\_

What concerns were addressed in therapy? \_\_\_\_\_

Was this experience helpful (please explain)? \_\_\_\_\_

\_\_\_\_\_

Has your child ever been hospitalized for emotional/behavioral problems No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, when/where was this: \_\_\_\_\_

Has your child been prescribed medications to control emotional/behavioral problems?

No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, please list medications, when prescribed, and by whom: \_\_\_\_\_

\_\_\_\_\_

To your knowledge, has your child experimented with alcohol/drugs? No \_\_\_\_\_ Yes \_\_\_\_\_

Are you concerned that your child might have or be developing a problem with alcohol or drugs?

No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

**D. Family**

Has this child ever experienced any parental separations, divorces, or death? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, when? \_\_\_\_\_ How old was the child at the time? \_\_\_\_\_

Please describe the circumstances. \_\_\_\_\_

If parents are separated or divorced, who has custody of this child? \_\_\_\_\_

How often does the other parent see this child? \_\_\_\_\_ Weekly or more often

\_\_\_\_\_ Once or twice a month \_\_\_\_\_ Few times a year \_\_\_\_\_ Never

Please list the age and sex for each sibling (including those deceased, and step-siblings):

Age	Sex	Relationship to this child	Living at home?

Other than any children already indicated above and parents, who else lives in the child's household? \_\_\_\_\_

Has anyone in the child's family had treatment for emotional problems? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please briefly explain (who/when): \_\_\_\_\_

Has anyone in your family ever attempted or committed suicide? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please briefly explain (who/when): \_\_\_\_\_

**E. Family Health**

Describe father's present health \_\_\_\_\_

Describe mother's present health \_\_\_\_\_

Have any family members had any of the following? If yes, please specify family member's relationship to this child.

Cancer \_\_\_\_\_

Severe head injury \_\_\_\_\_

Tourette's syndrome \_\_\_\_\_

Cerebral palsy \_\_\_\_\_

- Diabetes\_\_\_\_\_
- Heart disease\_\_\_\_\_
- High blood pressure\_\_\_\_\_
- Behavior disorder\_\_\_\_\_
- Emotional disturbance\_\_\_\_\_
- Mental Illness\_\_\_\_\_
- Mental retardation\_\_\_\_\_
- Nervousness\_\_\_\_\_
- Seizures/epilepsy\_\_\_\_\_
- Reading problem\_\_\_\_\_
- Speech/language problem\_\_\_\_\_
- Other significant health or emotional problem\_\_\_\_\_
- Food allergies\_\_\_\_\_
- Alcohol/drug abuse\_\_\_\_\_
- Kidney disease\_\_\_\_\_
- Migraine headaches\_\_\_\_\_
- Multiple sclerosis\_\_\_\_\_
- Physical disability\_\_\_\_\_
- Stroke\_\_\_\_\_
- Tuberculosis\_\_\_\_\_
- Alzheimer's disease\_\_\_\_\_
- Other Learning Problem\_\_\_\_\_
- Sickle cell anemia\_\_\_\_\_

**F. Child's Education**

School (name, district, address, phone)	Grade	Age	Teacher	Approx. grades

Describe any difficulties or problems your child is having in school:\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**G. Child's Development**

1. Pregnancy and delivery

Was this a planned pregnancy? No Yes

Was the mother under a doctor's care? No Yes

Number of previous pregnancies/miscarriages\_\_\_\_\_

Describe any complications that occurred during the pregnancy\_\_\_\_\_

What drugs/medications were used during the pregnancy?\_\_\_\_\_

\_\_\_\_\_

At this child's birth, what was the mother's age? \_\_\_\_\_ Father's age? \_\_\_\_\_

Length of pregnancy: \_\_\_\_\_ weeks Birth weight: \_\_\_\_\_ lbs \_\_\_\_\_ oz.

Length of labor: \_\_\_\_\_

Child's condition at birth: \_\_\_\_\_

Mother's condition at birth: \_\_\_\_\_

Length of stay in hospital: Mother \_\_\_\_\_ days    Child: \_\_\_\_\_ days

Is this child adopted?    No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please provide adoption history:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**H. Development**

Was this child breast fed or bottle fed? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, when was s/he weaned? \_\_\_\_\_

At what age was this child toilet trained?    Days: \_\_\_\_\_    Nights: \_\_\_\_\_

Did bed-wetting occur after toilet training?    No \_\_\_\_\_ Yes \_\_\_\_\_    If yes, until what age: \_\_\_\_\_

Did soiling occur after toilet training?    No \_\_\_\_\_ Yes \_\_\_\_\_    If yes, until what age: \_\_\_\_\_

Describe sleep patterns or problems: \_\_\_\_\_

**I. Medical Care**

Child's physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

How often does this child see a doctor? \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Is this child currently on any medication?    No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, indicate type and reason \_\_\_\_\_

List all childhood illnesses, hospitalizations, medications, allergies, head injuries, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?	Consequences

Is this child involved in any extracurricular activities, such as school sports or music programs, clubs or religious organizations? Please describe: \_\_\_\_\_

\_\_\_\_\_

Please describe your child's strengths and positive characteristics: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CLIENT PLEASE DO NOT WRITE BELOW**

***Clinician Review/Summary*** \_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Reviewing Clinician's Signature      Date

\_\_\_\_\_  
Supervisor's Signature      Date

\_\_\_\_\_  
Reviewing Clinician    PLEASE PRINT NAME