Kristin S. Swanson, Psy.D.
Licensed Clinical Psychologist
6107 Arlington Boulevard, Suite G
Falls Church, VA 22044
(p) 914.772.1892

CLIENT INFORMATION FORM

CHILD'S NAME:	BIRTHDATE:
Mother's Name: Financially Responsible: ☐Yes ☐No	Father's Name: Financially Responsible: ☐Yes ☐No
Marital Status: ☐ Married/Living Together ☐ Separated/Divorced ☐ Widowed	
Mother's Address: Check if child resides here ☐	Father's Address: Check if same as Mother's ☐ Check if child resides here ☐
Home Phone: Check if preferred number ☐ Check if okay for messages ☐	Home Phone: Check if preferred number ☐ Check if okay for messages ☐
Work Phone: Check if preferred number ☐ Check if okay for messages ☐	Work Phone: Check if preferred number ☐ Check if okay for messages ☐
Cell Phone: Check if preferred number ☐ Check if okay for messages ☐	Cell Phone: Check if preferred number ☐ Check if okay for messages ☐
Mother's Email:	Father's Email:
Occupation:	Occupation:
Emergency Contact: (Name, Phone Number, Relationship to Child)	
Referred by: Okay to send a thank you note? ☐ Yes ☐ No	

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CHILD DEVELOPMENTAL HISTORY

Pregnancy and Delivery

Prenatal Care (Please describe any medical illnesses or complications with mother or baby.)

Delivery (Was your child premature? Type of birth? Please describe any complications or problems.)

First Year of Life

Eating and sleep patterns

Temperament/Personality (ex. Was your baby easy or more challenging to soothe? Was s/he happy, easygoing, serious? What helped to calm him/her when distressed?)

Early Care (Who provided care for your child? Was s/he home with a parent? At home with another family member or care provider? In a daycare setting?)

Milestones

Motor (Sitting, Crawling, Walking)

Language/Communication (How did your child communicate before speech? When was his/her first word? When did s/he use small sentences to communicate?)

Delays in milestones (In what areas? Were early intervention services utilized?)

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Health and Medical History

Please list any childhood illnesses, hospitalizations, medications, allergies, accidents, surgeries, seizures, or any other medical conditions.

Family Living Arrangements

Who does your child live with? Please include all adults and children. In cases of dual custody, please indicate current schedule.

School Information

School Name

Teacher's Name/Grade

Individualized Education Program (IEP) or other accommodations ☐ Yes ☐ No

If yes, please provide brief description below.

Special skills/talents/interests

What does your child like to do? Briefly describe any hobbies, interests, preferred toys, etc.

Please indicate any other information you would like me to know about your child: