Lauren H. Kerstein LCSW, P.C.
Child and Family Psychotherapist

CLIENT INFORMATION SHEET-- Children

Child's Name: (*First, Middle, Last*): _____

Address: _____

_____

Home Telephone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____

Name of School/ Grade: _____

Mother/Guardian: _____ Father/Guardian: _____

Address: (if different than above) Address: (if different than above)

_____ _____

_____ _____

H Telephone: _____ H Telephone: _____

W Telephone: _____ W Telephone: _____

Cell Phone: _____ Cell Phone: _____

Profession: _____ Profession: _____

Email: _____ Email: _____

Step-Mother:_____ Step-Father:_____

Primary Care Physician

Name: _____

Address: _____

_____

Phone Number: _____

Is there information that would be helpful for me to obtain from your PCP? Yes No

Please list the members of your household: (name, age, relationship) _____

_____

_____

Referral Source

How did you hear about Lauren Kerstein? _____

5347 S. Valentia Way, Suite 120 Greenwood Village CO 80111 Phone 303.284.3603
lauren@laurenkerstein.com www.LaurenKerstein.com www.AutismAspergerBooks.com

Please include the address for your referral source if you have it: _____

_____

Medical/Psychological Information

Birth History: Please check one.

___ Natural Delivery ___ C Section

___ Natural Delivery with Complications ___ Adoption

___ Other _____

If complications, please explain: _____

Has your child been reaching her/his developmental milestones "on time"? Yes No

If no, please describe: _____

_____

Is your child taking any medications? Yes No

If yes, please list the medication and dosage. _____

_____

Has your child ever received psychotherapy services in the past? Yes No

If so, with whom? _____

_____

Please list any therapists and their phone numbers who are currently involved with your child:_____

_____

_____

Has the above-listed client received medical or psychological diagnoses in the past? Yes No

If yes, please list diagnoses. _____

_____

Please state the nature of your concerns regarding your child and family _____

_____

_____

Family History (Please check items that apply.) UK = Unknown, M=Maternal, P=Paternal, C=Child, S= Sibling

Diagnosis	Yes	No	UK	M,P,C,S	Diagnosis	Yes	No	UK	M,P,C,S
Depression					Metabolic Disorder				
Anxiety					Heart Disease				
Bipolar Disorder					Allergies				
ADD/ADHD					Asthma				
Sleep Disorder					Sinus Infections				

Autism/Asperger's/ PDD					Obsessive - Compulsive Disorder				
Tourette's					Sensory Integration				
Genetic Disorder					Substance Abuse				
Fragile X					Other:				