The Caring Center of Wichita, LLC
Child's Play Therapy Background Information

Child's Name:	Age:	Date:
Address:	Gender:	Date of Birth:
City:	State:	Zip:
	Phone:	
Emergency Contact		
Name:	Phone:	

Primary reason for seeking counseling:

_____

_____

_____

_____

Family History

Biological Parents

Never Married	Cohabiting	Married	Separated	Divorced	Widowed

Describe custody arrangements: _____

_____

_____

_____

~~ Feel free to use back side if you need more space ~~

This is a strictly confidential Patient Treatment Record. Disclosure or transfer is expressly prohibited by law.

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Parents and Guardians

Household One: Mother

Biological Parent	Stepmother	Adoptive Mother	Foster Parent	Legal Guardian	Other
Name:				Age:	Date of Birth:
Address:				City:	Zip:
Gender Identity: Female / Male	Email Address:			Mobile Phone:	
Permission to Contact by: Phone? Yes / No	Mail? Yes / No			Email? Yes / No	

Household One: Father

Biological Parent	Stepfather	Adoptive Father	Foster Parent	Legal Guardian	Other
Name:				Age:	Date of Birth:
Address:				City:	Zip:
Gender Identity: Female / Male	Email Address:			Mobile Phone:	
Permission to Contact by: Phone? Yes / No	Mail? Yes / No			Email? Yes / No	

Siblings and others living in Household One

Name:	Age:	Gender:
Name:	Age:	Gender:
Name:	Age:	Gender:
Name:	Age:	Gender:
Name:	Age:	Gender:

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Household Two: Mother (Complete if applicable)

Biological Parent	Stepmother	Adoptive Mother	Foster Parent	Lega Guardian	Other
Name:				Age:	Date of Birth:
Address:				City:	Zip:
Gender Identity: Female / Male	Email Address:			Mobile Phone:	

Permission to Contact by								
Phone?	Yes	No	Mail?	Yes	No	Email?	Yes	No

Household Two: Father (Complete if applicable)

Biological Parent	Stepfather	Adoptive Father	Foster Parent	Lega Guardian	Other
Name:				Age:	Date of Birth:
Address:				City:	Zip:
Gender Identity: Female / Male	Email Address:			Mobile Phone:	

Permission to Contact by								
Phone?	Yes	No	Mail?	Yes	No	Email?	Yes	No

Siblings and others living in Household Two (Complete if applicable)

Name:	Age:	Gender:
Name:	Age:	Gender:
Name:	Age:	Gender:
Name:	Age:	Gender:
Name:	Age:	Gender:

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Medical History

Current Medications

Name	Dosage	Condition/Diagnosis

Surgeries and Major Illnesses

Surgery or Illness	Date

Primary Care Physician

Doctor's Name:	Phone:

Specialty Doctor(s)

Doctor's Name:	Phone:
Specialty:	
Doctor's Name:	Phone:
Specialty:	

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Social and Emotional Development

List your child's greatest strengths:

_____

_____

_____

List your child's weaknesses or areas that need improvement:

_____

_____

_____

List your child's main difficulties at school:

_____

_____

_____

List your child's main difficulties at home:

_____

_____

_____

Briefly describe your child's hobbies or interests:

_____

_____

_____

_____

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Does your child have a history of abuse? □ Yes □ No (Skip to Consent)

If yes, please check all that apply:

□ Physical Abuse □ Sexual Abuse □ Emotional Abuse □ Neglect

Please describe abuse history: _____

_____

_____

_____

Please describe legal action pending abuse history if applicable: _____

_____

_____

Consent for Child Treatment

I am the parent/legal guardian of _____ (child's name). I give permission for my child to receive mental health services from any counselor or therapist employed or under contracts with the Caring Center of Wichita, LLC.

_____/_____
Parent, Guardian, Representative signature Date

_____/_____
Parent, Guardian, Representative printed name Relationship to Child