CCGC
COMMUNITY CHILD GUIDANCE CLINIC

Locations
317 North Main Street and 1075 Tolland Turnpike
Manchester, CT 06042
860.643.2101 | www.ccgcinc.org

Child Information Packet

Please complete the following information as thoroughly as possible. This information helps us to better understand your child, and you may prefer not to discuss some of the following information with your child present. Some of these questions may not apply to you, the family, or your child and we ask that you mark N/A in those areas. Some questions may not have an easy answer, or may require that you look up names, addresses, or family records. Please think about the questions carefully and provide the most factual or accurate answer possible. This information will be considered strictly confidential and will not be shared with anyone outside the clinic without your signed permission.

Child's name: _____ DOB: _____

Completed by: _____ Relationship: _____

Date of intake/inquiry: _____

Please tell us who referred you to our clinic: _____

PRESENTING PROBLEM

What do you think your child and/or family may need help with?

What do you consider to be your child's emotional/behavioral difficulties? When and where do they occur?

When did these difficulties start?

ABOUT YOUR CHILD

What is your child's race and/or ethnic heritage?

How would you describe your child's personality?

What is your child good at?

What are his or her interests/extra-curricular activities (sports, hobbies, organizations, clubs, or groups)?

What chores or jobs is your child responsible for? How well do they complete the task?

How does your child do with self-care tasks (getting dressed, using the bathroom on his or own, etc.)?

How does your child express his or her feelings (anger, frustration, sadness, joy, etc.)?

Does your child have a best friend, friends, or boy/girlfriend? How does s/he get along with these peers?

Does your child work, or has s/he ever been employed? What type of work, and what was his/her performance like?

DEVELOPMENTAL HISTORY

Was this pregnancy planned? ◯ YES ◯ NO

Was it a convenient time to have a child? ◯ YES ◯ NO

What type of prenatal care did you receive? Did you take any prescribed medications during your pregnancy (if so, what medications)?

Were there any medical, emotional, or environmental complications during the pregnancy (for example: diabetes, anemia, infections, emotional upset, or exposure to lead)?

Were there any complications during the birth? If so, please explain.

Child's height and weight at birth: _____

Was the child breast or bottle-fed, and when was the child weaned? _____

MILESTONES

Activity	Age acquired	How long did it take for him or her to learn this skill? Did you have any concerns with their ability?
Walking		
Speaking single words		
Speaking sentences		
Toilet trained		

How would you describe your child's temperament and behavior during their early childhood years (birth to age 5)? Please mark each of the following characteristics:

- ☐ Active
- ☐ Quiet
- ☐ Aggressive
- ☐ Withdrawn
- ☐ Fearful
- ☐ Affectionate
- ☐ Happy
- ☐ Social
- ☐ Made friends easily
- ☐ Frequently cried
- ☐ Independent
- ☐ Easily frustrated
- ☐ Irritable
- ☐ Angry
- ☐ Curious

Please describe how your child interacted with peers/siblings during their early childhood years:

Were there any stressors present during your child's early childhood years?

EDUCATIONAL INFORMATION

How does your child feel about school? How is his/her behavior while at school, and how does s/he get along with classmates?

What are your child's grades like?

What grades, if any, has your child repeated?

Does your child have an Individualized Education Plan or a 504? When did s/he start receiving this service?

How many days of school has your child missed within the last 12 months? _____

Has your child been suspended or expelled from school within the last 12 months? ◯ YES ◯ NO

Please provide us with the names of the schools that your child has attended:

Name of School	Grades Attended	Dates Attended

Has your child ever been arrested? If so, when and under what circumstances?

MEDICAL INFORMATION

Does your child have any of the following? Check all that apply.

- ☐ Allergies
- ☐ Asthma
- ☐ Convulsions
- ☐ Diabetes
- ☐ Ear Infections (chronic)
- ☐ Fainting
- ☐ Hearing impairment
- ☐ Headaches/Migraines
- ☐ Lead Poisoning
- ☐ Obesity
- ☐ Seizure Disorder
- ☐ Vision impairment
- ☐ Other: _____

Is your child currently taking any prescribed medications? Please provide the name, dose, and prescriber of the medication:

Medication:	Dose and Frequency:	Prescribing physician:

Has your child ever been hospitalized for behavioral or mental health reasons? This can include trips to the emergency department (E.D.) or overnight stays in a psychiatric hospital, such as the Institute of Living; a stay in a psychiatric unit of a general hospital; or a stay in a pediatric unit for behavioral reasons if a specialized bed was unavailable. If so, please complete the following: *(Note: Reasons may include self-harm, out-of-control behavior, suicidal comments, etc.)*

Hospital	Reason	E.D. Only?	Dates of Stay

Has your child ever been placed in out-of-home care for psychiatric reasons (group home, residential facility)? If so, please complete the following:

Facility	Reason	Dates of stay

Has your child received outpatient, intensive outpatient, in-home therapy, or partial hospitalization treatment? Did you find this service helpful?

Name of provider	When did you receive this service?	Helpful?

Has your child ever had any significant medical illnesses or surgeries? If yes, please explain:

Please provide the name of your child's pediatrician and the date of their most recent physical exam:

Have you ever contacted 211 for mobile or non-mobile crisis intervention? If so, when and under what circumstances?

FAMILY INFORMATION AND HISTORY

Who do you consider to be in your child's family? Please include any step or half-siblings, stepparents, or family members such as grandparents, uncles, aunts, to include other caregivers involved in child's life, that are a significant part of your child's family system in the chart below.

On a scale of 1-10, where 1 is the worst and 10 is the best, please rate the quality of the relationship between the child and the family member.

Name	Date of Birth	Relationship to child	Quality (1-10)

Who is the child's primary guardian? Is there a custody/visitation agreement?

What is the extent of parental involvement by each parent and/or caregiver?

When did you and the other parent or caregiver meet, were you married, and/or how long have you been together?

Were there any separations and/or divorce during the course of a marriage/partnership? If so, when did they occur, and how did your child respond?

How do you and your current or ex-partner do with co-parenting? What do you agree/disagree on with regard to raising your child?

Please identify any family members who have a diagnosed mental health disorder. This information helps us to better assess and treat your child.

Disorder	Family Member(s)	Received Treatment? What kind?
Anxiety Disorders		
Attention Deficit/Hyperactivity Disorder		
Autism		
Bipolar Disorder		
Conduct or Oppositional Defiant Disorders		
Dissociative Disorders		

Depressive Disorders		
Elimination, Feeding/Eating or Sleep/Wake Dis.		
Intellectual/Learning Disorders		
Obsessive Compulsive Disorders		
Personality Disorders		
Trauma/Stress Disorders (e.g., PTSD)		
Schizophrenia Spectrum Disorders		
Sexual Disorders/Dysfunctions		
Substance Abuse (narcotics or alcohol)		
Other		

Are any of the family members in the child's immediate family system taking medication to treat the above disorders? If so, please provide the names of the medication and whether it was effective:

Has there been spousal abuse, child abuse, and/or sexual abuse in the history of the family?

Have you or your child ever had involvement from the Department of Children and Families? If so, please describe your experience with DCF and whether you found the intervention helpful.

Has it ever been necessary for the child, or his or her siblings, to be placed out of the home in substitute care? If so, when, where, and under what circumstances?

Have you and your child ever had to relocate? If so, how many times and where have you moved?

Have there been any deaths in the family? If so, who was involved, when did the death occur, and what were the circumstances and/or causes of death (please note any family suicides as well):

Do you have any ongoing financial or legal concerns that are a stressor for you and your household?

PARENT-CHILD RELATIONSHIP

Please describe the relationship you have with the child:

At this time, are you happy with the relationship with the child?

How does the child respond to family members and/or other adults in their lives?

How do you discipline the child?

What are things you enjoy about the child?

FAMILY RESOURCES

The following information helps us identify strengths and what resources may be available to better assist your child.

Please describe relationships within your extended family or family friends that your child responds particularly well to. What do you think makes this such a positive relationship?

Please describe the spiritual or religious faith of you and/or your family members. What do you think your child's spiritual/religious beliefs are?

Do you attend a church, synagogue, mosque, or other religious institution, if only once in a while? If so, please share which religious institution you attend and how your child responds to the service, (and whether the service is adult or child-oriented):

Please describe any cultural traditions that your family practices:

Have you had any assistance from other community providers? If so, please tell us who and whether you found the service helpful.

It is very important for parents to maintain their health and well-being. How do you manage your stress? Who can you count on to help you when things are tough?

Thank you for your time in providing this information regarding the child. It will greatly improve our abilities in working with the child.