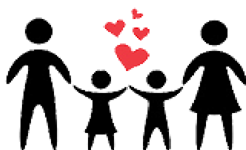
Adoption & Attachment Therapy Partners, LLC

Arleta James, LPCC
1201 Canyon View Road
Sagamore Hills, OH 44067



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Helping adoptive parents forge strong connections among all family members via adoption-attachment-trauma informed therapies.

Child Application Form

PLEASE PRINT

Name of Child____ Birthdate____________________________

Parent's name

(Parent 1)____ DOB_________________________________

(Parent 2)____ DOB_________________________________

Address____

____

Contact Information

(Daytime)____ (Evening)____________________________

(Parent 1) Cell Phone__________________________________

(Parent 2) Cell Phone__________________________________

(Parent 1) Email______________________________________

(Parent 2) Email______________________________________

Level of Education

(Parent 1)____

(Parent 2)____

(School of Child) ______________________________________ Grade________________________________

Others living at home:

Name	Sex	Birth date	Age	School/Grade
________________________________	____	__________	_____	__________
________________________________	____	__________	_____	__________
________________________________	____	__________	_____	__________
________________________________	____	__________	_____	__________

Parent 1 Employed by____

Business Telephone____

Soc. Sec. #____

Parent 2 Employed by____

Business Telephone____

Soc. Sec. #____

Family Physician____

Referred by____

Telephone#____

Chief Complaint & Problem____

____

____

Is Child Adopted? __________________________

If So, At What Age? ________________________

Child's First Name Prior to Adoption____

Complications of Birth & Delivery____

____

____

Have there been any physical or emotional separations (i.e. death, hospitalizations, depression) between child and caretaking adult during the first 26 months of life? ____

If so, please elaborate in CHILD'S HISTORY report.

Is there, as far as you know, any possible history that could be considered abusive? If so, indicate type(s) and age of occurrence. ____

____

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If it is hard to remember ages, please simply check the problem areas or areas you feel were/are advanced or slow in development.

Age he/she:

held head up ____________
crawled ____________
walked with help ____________
used sentences ____________
fed self ____________
dressed alone ____________
turned over ____________
sat ____________
walked alone ____________
was weaned ____________
said "no, no" to everything ____________
smiled at parents ____________
pull up at crib ____________
said 4-10 words ____________
helped with dressing ____________
dry during day ____________
dry during night ____________

Does he/she:

have blank spells ____________
rock ____________
shuns attention ____________
have temper tantrums ____________
have falling spells ____________
have unusual fears
bump head ____________
hold breath ____________
show dare devil behavior ____________
have sleep problems ____________
have eating problems ____________

Is he/she:

shy or timid _________
affectionate _________
well-coordinated _________
impulsive _________
stubborn _________
right/left-handed _________
clumsy _________

PREVIOUS TESTING OR THERAPY:

Dates: ____

____

Place: ____

____

With whom: ____

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