

*This information is personal & confidential and will only be shared between you and your counselor.*

## Child/Family History

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Who has custody of the child? \_\_\_\_\_

Are there any outside agencies involved? Y / N If yes please explain who and why:

\_\_\_\_\_

List people who live in the home:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Marital Status of parents (circle): Married Separated Divorced Widowed Never Married

To what adult is he/she closest (mom, dad, grandparent, etc.): \_\_\_\_\_

Has there been any recent life changing events/disruptions? Y / N If yes, please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## History of problem

Is your child experiencing now or have they experienced any of the following in the past 6 months:

- |  |  |
|--|--|
| <input type="checkbox"/> Appetite change (more/less)               | <input type="checkbox"/> Loss of interest in activities/things |
| <input type="checkbox"/> Difficulty sleeping                       | <input type="checkbox"/> Depressed mood                        |
| <input type="checkbox"/> Fatigue/loss of energy                    | <input type="checkbox"/> Irritability/anger/agitation          |
| <input type="checkbox"/> Difficulty concentrating/making decisions | <input type="checkbox"/> Significant weight loss or gain       |
| <input type="checkbox"/> Low self-esteem                           | <input type="checkbox"/> Feeling worthless                     |
| <input type="checkbox"/> Recurrent thoughts of death/suicide       | <input type="checkbox"/> Feeling hopeless                      |
| <input type="checkbox"/> Recurrent thoughts or acts of self-harm   | <input type="checkbox"/> Feeling keyed up or on edge           |
| <input type="checkbox"/> Panic attack                              | <input type="checkbox"/> Excessive worry                       |
| <input type="checkbox"/> Muscle tension                            | <input type="checkbox"/> Heart palpitations/racing             |
| <input type="checkbox"/> Fear of losing control                    | <input type="checkbox"/> Nightmares                            |
| <input type="checkbox"/> Anxiousness/nervousness                   | <input type="checkbox"/> Day dreaming                          |
| <input type="checkbox"/> Wetting/bowel accidents                   | <input type="checkbox"/> Difficulty making friends             |
| <input type="checkbox"/> Academic problems: Grades Social Other    |  |
| <input type="checkbox"/> Bullying: If so, how: _____               |  |
| <input type="checkbox"/> Family Concerns: If so, how: _____        |  |

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**What concerns you most about your child?** \_\_\_\_\_

\_\_\_\_\_

**When did you first think there might be a problem?** \_\_\_\_\_

\_\_\_\_\_

**What do you think caused the problem?** \_\_\_\_\_

\_\_\_\_\_

**Have you noticed any changes in the patterns your child normally:**

**Eats:** \_\_\_\_\_

**Sleeps:** \_\_\_\_\_

**Is the problem worse at certain times, situations, places?** \_\_\_\_\_

**Has your child ever done any of the following?**

\_\_\_ Stolen/shoplifted

\_\_\_ Set fires

\_\_\_ Physically assaulted anyone

\_\_\_ Abused drugs/alcohol

\_\_\_ Acted out sexually

\_\_\_ Ran away

\_\_\_ Been cruel to animals

## **School History**

**School:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Special Services** (*circle all that apply*): None LD BD EMR OT Speech

**Has there been a noticeable change in grades?** Y / N **If yes, when?** \_\_\_\_\_

**Has he/she ever been suspended or expelled?** Y / N **If yes, when?** \_\_\_\_\_

**How does your child get along with others?** \_\_\_\_\_

**How many schools has he/she attended during the past three years?** \_\_\_\_\_

## **Previous Mental Health Services**

**Has he/she received counseling services before?** Y / N **If yes, when?** \_\_\_\_\_

**Where?** \_\_\_\_\_ **Reason for discontinuing?** \_\_\_\_\_

**Has he/she had any psychiatric hospitalizations?** Y / N **If yes, when?** \_\_\_\_\_

**Where?** \_\_\_\_\_ **Reason?** \_\_\_\_\_

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## **Medical History**

**Child's personal physician:** \_\_\_\_\_

**Is the child on any prescription medications?** Y / N

**If yes, please list:**

<b>Medication (and dose)</b>	<b>Condition</b>	<b>Prescribing Doctor</b>
_____	_____	_____
_____	_____	_____

**Has he/she started puberty?** Y / N **If yes, approximately when did it start?** \_\_\_\_\_

**Do you have any medical concerns about your child?** \_\_\_\_\_

\_\_\_\_\_

## **Developmental History**

**Were there any medical problems or complications during the pregnancy or birth for the mother or child? If yes, please describe:**

\_\_\_\_\_

\_\_\_\_\_

**Was this a planned pregnancy?** Y / N **Child's birth weight:** \_\_\_\_\_ lbs. \_\_\_\_\_ oz.

**During the pregnancy, did the mother use drugs, alcohol, cigarettes, or medications?**

**If yes, please list:**

\_\_\_\_\_

**During the first year, how would you describe your child?:** \_\_\_Cuddly \_\_\_Affectionate  
\_\_\_Sickly \_\_\_Colicky \_\_\_Poor Sleeper \_\_\_Easy to care for \_\_\_Difficult to care for

**Did you have any concerns with your child's development? If so, please describe:**

\_\_\_\_\_

\_\_\_\_\_

## **Family / Social History**

**If child does not live with both parents, what is the visitation arrangement with parent not in-home?** \_\_\_\_\_

**Has the child ever lived with any other person beside parent? If yes, please explain (include relationship, dates):**

\_\_\_\_\_

\_\_\_\_\_

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**Has he/she ever been abused physically, sexually, or emotionally? If yes, please explain:**

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**Has he/she ever witnessed violence in the home or had a severely traumatic experience? If yes, please explain:**

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**How do you discipline your child?** \_\_\_\_\_

**Has this method been effective?** \_\_\_\_\_

**What chores does your child have?** \_\_\_\_\_

**Does he/she usually accomplish chores?** \_\_\_\_\_

**How much time does your child spend watching television per day?** \_\_\_\_\_

**Playing video games?** \_\_\_\_\_

**What are your child's strengths / good qualities?** \_\_\_\_\_

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**What hobbies, activities, and interests does your child enjoy being involved in?**

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**How does your child interact with or get along with you?** \_\_\_\_\_

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**Does your child like/dislike self?** \_\_\_\_\_

**Is there anything you would like to add regarding your child?** \_\_\_\_\_

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**Read, sign and accept the policy below:**

If parents are divorced or separated, we need to have the appropriate court documents in the child's records showing who has custody and who is responsible for seeking medical care/counseling if it is so indicated in the court document.

This office does not get involved in custody and financial disputes. The person signing for the responsibility for the child will be the person indicated as the one financially responsible for services rendered by our counselors. Any financial arrangements made between divorced/separated parents are to be handled between the parents.

I, (Parent/Client/Guardian), understand the above statements and agree that this is for the best interest of the Client.

I, (Parent/Client/Guardian), authorize the individual(s) listed below to make appointments for and/or bring the Client to the appointments on my behalf.

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Relationship**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Relationship**

\_\_\_\_\_  
**SIGNATURE OF PARENT/CLIENT/GUARDIAN**

\_\_\_\_\_  
**DATE**