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

_____

_____

_____

History of problem

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

____ Appetite change (more/less)
____ Difficulty sleeping
____ Fatigue/loss of energy
____ Difficulty concentrating/making decisions
____ Low self-esteem
____ Recurrent thoughts of death/suicide
____ Recurrent thoughts or acts of self-harm
____ Panic attack
____ Muscle tension
____ Fear of losing control
____ Anxiousness/nervousness
____ Wetting/bowel accidents
____ Academic problems: Grades Social Other
____ Bullying: If so, how:_____
____ Family Concerns: If so, how: _____

____ Loss of interest in activities/things
____ Depressed mood
____ Irritability/anger/agitation
____ Significant weight loss or gain
____ Feeling worthless
____ Feeling hopeless
____ Feeling keyed up or on edge
____ Excessive worry
____ Heart palpitations/racing
____ Nightmares
____ Day dreaming
____ Difficulty making friends

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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____
Abused drugs/alcohol____
Ran away_____
Set fires____
Acted out sexually____
Been cruel to animals____
Physically assaulted anyone____

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?**_____

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

Where? _____ **Reason?**_____

Medical History

Child's personal physician: _____

Is the child on any prescription medications? Y/N
If yes, please list:

Medication (and dose)	**Condition**	**Prescribing Doctor**
_____	_____	_____
_____	_____	_____

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,

describe:_____

_____

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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):

_____

_____

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

_____

_____

_____

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

_____

_____

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? _____

_____

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

_____

_____

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**