**Demographics**:

Child's Name: ______________________________

Birthdate: ____________________ Age: _____________

Parent/Guardian Name(s): ______________________________

______________________________

Client lives with (please circle all that apply):

| | | |
|---|---|---|
| Mom | Aunts/Uncles | Foster Parents |
| Dad | Siblings | Other _______________ |
| Grandparents | Cousins | |

Phone Number(s): Address:

_______________________________ _______________________________

_______________________________ _______________________________

Any other agencies or therapists involved with your family:

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

**Mental Health**:

Briefly describe the reasons you have brought your child to counseling today:

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Describe any prior counseling and what, if any, prior diagnoses your child has received:

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Medications your child currently takes and who prescribes them?

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Circle any major events or traumas your child has experienced:

Recent move
Recent change in family finances
Parent separation or divorce
Change in custody agreement
Loss of a loved one
Separation from caregivers
Physical abuse
Neglect
Sexual abuse or rape
Surviving a natural disaster
Head injury
Painful or scary medical treatment
Serious car accident
Hearing about or witnessing a violent death
Known someone who committed suicide

Rate any symptoms your child is experiencing on a scale from 1-3 where 3 is the most serious:

___ Nightmares
___ Trouble falling asleep
___ Trouble staying asleep
___ Becomes upset when reminded of the past
___ Has unwanted thoughts
___ Avoids certain people, places, or things
___ Less interest in doing things
___Trouble feeling close to others
___ Never seems to cry or cries all the time
___ Significant loss or gain of weight
___ Change in appetite
___ Feeling hopeless
___ Irritable
___ Fits of anger
___ Trouble paying attention
___ Being overly careful
___ Jumpy or easily startled
___ Fidgety
___ Can't sit still
___ Easily distracted
___ Difficulty waiting turns
___ Trouble following directions
___ Interrupts or blurts out answers
___ Cannot stay with one activity long
___ Talks all the time
___ Does not seem to listen
___ Often loses things
___ Does things without thinking first
___ Risky behavior
___ Feeling sad
___ Feels discouraged or like a failure
___ Feelings and statements of guilt
___ Self Harm or Cutting
___ Talks about or has attempted suicide
___ Trouble making decisions
___ Trouble with self-esteem or body image
___ Can't seem to get motivated
___ Can't follow through on tasks or commitments
___ Tired during the day
___ Worries a lot
___ Daydreams too much
___ Starts fights with other children
___ Not following rules or complying with requests
___ Trouble understanding other people's feelings
___ Teasing others
___ Blaming others
___ Refusing to share (5 years and older)
___ Taking things that do not belong to him/her
___ Destroying property
___ Setting fires
___ Sexually inappropriate behavior
___ Tired
___ Restless
___ Panic or Anxiety Attacks
___ Trouble leaving primary care giver
___ Refusing to attend school
___ Frequently in trouble at school
___ Often argues with adults
___ Deliberately annoys others
___ Refusing to eat or throwing up to lose weight
___ Others: ______________________________

Comments on any of the above:

**Interpersonal and Social Skills:**

Do you have concerns about your child's interactions with other children or his/her ability to make and keep friends?

**Physical Health:**

Your child's doctor:
Name:
Contact Information:

Any special dietary restrictions or allergies:

Any delays or particular successes in terms of pregnancy, delivery, or development?

Has anyone ever told you that your child has any kind of delays or impairments?

Any history of major illness or surgery?

Has your child ever caused, threatened to cause, or attempted to cause deliberate harm to him/herself or anyone else?

**Substance Abuse**:

Are substances an issue in this child's life?
______________________________
______________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Would your family be receptive to a substance abuse treatment referral? ______________________

**Vocational/Educational**:

What school does your child attend? __________________________________________________
Grade: ____________________
Is your child performing at grade level? _________________
Does your child have an IEP or 504 Plan? ______________
If not are you interested in pursuing this? _______________

Does your child have a history of being in trouble at school, being truant, suspended or expelled?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Is your child employed?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Family:**

Please tell me a little about your family history:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please describe your natural support system:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

## Cultural and Spiritual:

To what race, ethnicity, or culture does your family identify?

______________________________
______________________________
______________________________
______________________________
______________________________

Does your family subscribe to a particular spiritual background or attend church regularly?

______________________________
______________________________
______________________________

Are there sexual identity/orientation issues present in your family of which you would like to make me aware?

______________________________
______________________________
______________________________

Are you concerned about ways in which cultural, spiritual or sexuality issues may affect your counseling?

______________________________
______________________________
______________________________

**Legal Involvement**:

Does your family currently have any involvement with any court system including criminal, juvenile, and family courts?

______________________________
______________________________
______________________________

**Your Goals**:

Describe what you would like your child to get out of his/her time in counseling?

______________________________
______________________________
______________________________

Have your child describe, if they are able, what they hope to get out of counseling:

______________________________
______________________________
______________________________