a lifetime to grow

Please fill out the entire form, answering the questions as they pertain to your child or teen. Leave blank any that are unclear or that you want additional clarification on. Thank you.

General Information

Child's name: _____Nickname: _____Date of Birth: _____/_____/_____

Sex: Male _____ Female _____ SSN: _____ Today's date: _____/_____/_____

Parent's Name: _____Home phone: (____) _____ Cell: (____) _____

Address:_____ City: _____ State: _____ Zip: _____

Employer: _____Work phone: (_____) _____ Email: _____

Parent's Name: _____ Home home: (____) _____ Cell: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work phone: (____) _____ Email: _____

Who will be responsible for making/keeping appointments? _____

Ok to leave phone message? Yes No Which number? _____ Ok to send mail? Yes No

Emergency contact/Relation: _____ Phone: (____) _____ Alt phone:(____)_____

Child's primary care provider: _____Clinic name/phone:_____

Allergies: _____ Medical conditions: _____

Grade level and school: _____Interests/hobbies: _____

I was referred by: _____

Insurance Information

Insurance Provider: _____Subscriber's name: _____Subscriber's birthdate: _____/_____/_____

Name of employer: _____ Subscriber's address (if different than above): _____

Insurance phone: _____ Address: _____

ID#: _____ Group #: _____

**A copy of your card will be made if you would like your insurance to be billed for reimbursement.

Therapy Goals and History

What brings you and your child in? _____

_____

What would you like to be different? _____

Who supports you and your family in your decision to begin counseling? _____

_____

Has your child seen a therapist before? Yes ____ No ____ When? _____From 1-10, rate previous experiences: _____

Name(s) of previous therapist(s): _____ Phone: (____) _____

_____

What helped? _____ What didn't? _____

Family History

Who lives in the home? Names, ages and relationship. _____

_____

_____

Who are the significant adult figures in your child's life? _____

Describe significant changes/transitions in your child's life and the age that they occurred. For example, divorce, moves, change in schools, death/loss, removal from parents' care.

_____

_____

_____

_____

If parents are divorced or separated, what are the current custody and visitation arrangements? _____

_____

Symptom Checklist

Check 0, if you are not currently concerned about the symptom; 1, if it is a mild concern; 2, if it is a moderate concern and 3, if it is a serious concern.

Symptom	0	1	2	3	Symptom	0	1	2	3
Depressed mood/sadness					Sleep Trouble				
Grief and loss					Fatigue/low energy				
Loss of appetite					Weight gain or loss				
Apathy or lack of motivation					Suicidal thoughts or attempts				

Symptom	0	1	2	3	Symptom	0	1	2	3
Substance abuse					Feelings of worthlessness				
Headaches/stomach pain					Social isolation				
Guilt/Shame					Poor attention or focus				
Hyperactivity					Self-esteem issues				
Mood swings					Unusual or racing thoughts				
Anger					Aggression/violence				
Anxiety or worry					Panic attacks				
Phobias					Obsessions				
Compulsive behavior					Victim of abuse or trauma				
Feeling detached or distant					Hearing or seeing things				
Self-harming or cutting					Difficulty making/keeping friends				
Exposure to domestic violence					Legal trouble				
Learning difficulties					Tolieting issues				
Behavior concerns at school					Tantrums/fits				
Poor grooming					Irritability				
Binging/purging					Anorexia				
Tearfulness					Chronic medical condition				
Defiance/oppositional behavior					Victim of a crime				
Nightmares					Other: _____				
Other: _____					Other: _____				

Psychiatric Treatment History

Has your child seen a psychiatrist in the past? Yes ____ No ____ Name/phone: _____

Is he or she currently seeing a psychiatrist? Yes ____ No ____ Name/phone: _____

Current medications and supplements, along with dosage: _____

_____

_____

Has your child been hospitalized for emotional, psychological or substance use issues? Yes ___ No ___

If yes, when and for how long: _____

Location/Facility name: _____

Has anyone else in your family had similar psychological or emotional difficulties and/or concerns? Please explain.

_____

_____

_____

_____

Developmental History

Were there any complications with the pregnancy and delivery of your child? _____ If yes, explain. _____

_____

_____

Have you or anyone else had concerns about your child's development? _____ If yes, explain. _____

_____

_____

Have you or anyone else had concerns about your child's social development? _____ If yes, explain. _____

_____

_____

Have you or anyone else had concerns about the intellectual or academic functioning of your child? _____ If yes, explain.

_____

_____

Substance Use Inventory
Please indicate if your child has used or is currently using the following substances. Please list other family members who have used or are currently using.

	Age of child's first use	When last used	Current frequency and amount	Previous treatment	Family members with past or current use issues.
Alcohol				Yes No	
Marijuana/ Hashish				Yes No	
Meth/ "Speed"				Yes No	
Cocaine/ Crack				Yes No	
Heroin				Yes No	

	Age of child's first use	When last used	Current frequency and amount	Previous treatment	Family members with past or current use issues.
Prescription drugs				Yes No	
Inhalants				Yes No	
Ecstasy/ Molly				Yes No	
Mushrooms				Yes No	
Caffeine				Yes No	
Nicotine				Yes No	
Other:				Yes No	
Other:				Yes No	

Socio-Economic History:

Living Situation
- Housing adequate
- Homeless
- Housing overcrowded
- Housing dangerous/ deteriorating
- Living companions unstable

Employment
- Employed and satisfied
- Employed but dissatisfied
- Unemployed
- Conflicts at work
- Unstable work history
- Disabled
- Student/underage

Family Financial Situation
- No current financial stress
- Large debt
- Low income
- Impulse spending
- Relationship conflict over money

Family's Social Support System
- Supportive network of friends and family
- Few friends
- New to the area
- No friends
- Geographically or emotionally distant from family

Parental Legal History
- No legal problems
- Parole/probation
- Arrest(s) not substance related
- Arrest(s) substance related
- Jail/Prison time

Last legal difficulty: _____

_____

Cultural and Spiritual History

Cultural identity: _____Spiritual identity: _____

Importance of spirituality/religion: Low Med High

Is your child or family currently active in your community? _____If so, describe: _____

Does your child or family currently engage in spiritual activities? _____If so, describe: _____