

CLIENT INFORMATION

Child's First Name	Middle	Last	Date Completed (MM/DD/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Gender	Date of Birth (MM/DD/YYYY)		
<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="text"/>		
How Were You Referred?	Referrer's Name	Other Referrer	
<input type="checkbox"/> Google Search <input type="checkbox"/> Psychology Today <input type="checkbox"/> Other Professional	<input type="text"/>	<input type="checkbox"/> Other <input type="text"/>	
Completed By (If Not Client)	Phone	Relationship	
	<input type="text"/>	<input type="text"/>	
Primary Reason For Appointment			
<input type="text"/>			

PERSONAL HISTORY

Following are questions regarding your child's personal history. The purpose of this form is to gather initial background information in order to save time in the first session. Please feel free to skip questions that do not apply to your child's situation or that you are not comfortable answering. Please note that the more information you share, the more complete picture your counselor will have of your child's situation. You will have an opportunity in your first session to provide more details and ask questions about this form.

Has your child ever attended Counseling Before? Yes No If so, with whom?

Details (When, How Long, etc.):

Is he/she a current patient of a Psychiatrist? Yes No If so, of whom?

Has your child ever attempted suicide or planned to hurt him/herself? Yes No If so, When?

Details:

Does your child currently have any thoughts and/or feelings of wanting to physically harm him/herself? Yes No

If so, please explain:

Has your child ever been under treatment for substance abuse? Past Current N/A

If so, please explain:

Has your child ever (or do you worry that he/she might have) suffered abuse? Emotional Physical Sexual

If so, please explain:

Has your child ever received a formal diagnosis from a mental health professional? Yes No

If so, please explain:

Is there any history of mental disorders/illness in your child's family? Yes No

If so, please explain:

MEDICATIONS (Please note medications your child is currently taking)

Medication	Dose	Start Date	Who Prescribes?	Purpose

Is there anything else we should know about your child's medication(s) (i.e. ot her prescriptions, supplements, side effects, etc.)

RELATIONSHIPS (Please note the child's significant family members, friends, etc.)

First Name	Relationship	Age	Live With?	Notes
			<input type="checkbox"/> Yes	
			<input type="checkbox"/> Yes	
			<input type="checkbox"/> Yes	
			<input type="checkbox"/> Yes	
			<input type="checkbox"/> Yes	
			<input type="checkbox"/> Yes	
			<input type="checkbox"/> Yes	
			<input type="checkbox"/> Yes	

How does your child typically relate to other people (Check all that apply):

- Affectionate
 Aggressive
 Avoidant
 Fight/Argue Often
 Follower
 Friendly
 Leader
 Outgoing
 Shy/Withdrawn
 Submissive
 Other (Please Explain)

EDUCATION

How would you rate your child's academic performance:

- Poor
 Could Use Improvement
 Average
 Above Average
 Excellent

School: Grade: Primary Teacher:

Does your child have an IEP, 504 plan, or other special provisions at school? Yes No

Has your child ever repeated a grade? Yes No If so, which one(s):

Please note any other significant educational information (Achievements, IEP info, learning disabilities, school changes, etc.)

CULTURE/ETHNICITY

With which cultural or ethnic group(s), if any, does your child identify?

Please describe any issues/challenges your child is experiencing due to cultural or ethnic issues:

SPIRITUALITY/RELIGION

How important to your child's family are spiritual/religious matters? Not Minor Moderately Very

Is your child affiliated with a spiritual/religious group? Yes No If Yes, describe:

Please share any other important thoughts/notes about spirituality/religion you feel it important that your counselor understand:

LEGAL

Is your child or family involved in any active legal cases (custody, criminal, other)? Yes No

If so, please explain:

Has your child ever been arrested or involved in criminal activity? Yes No

If so, please explain:

Please share any other important current or past legal history you feel it is important that your counselor be aware of:

LEISURE/RECREATION

Please describe any leisure/recreational/hobby activities that your child engages in.

Activity	How Often Now?	How Often In the Past?

NUTRITION

How would you rate the quality of your child's nutrition/diet/eating habits?

Poor Could Use Improvement Adequate Above Average Excellent

Please share any food/nutrition related thoughts/issues/challenges you feel your counselor should be aware of:

MEDICAL

How would you rate your child's current overall physical health?

- Poor Could Use Improvement Adequate Above Average Excellent

Please describe any current health concerns and/or recent changes in your child's health:

Please describe any family history of medical problems:

Please check if there have been any recent changes in the following for your child:

- Sleep Eating/Diet Behavior Energy Level Physical Activity General Mood Weight Stress

Please describe any changes you checked above:

What is the name of your child's primary physician?

SYMPTOM CHECKLIST

Please check any of the following that you feel apply to your child or that your child thinks about his/her self (on a regular basis):

- | | | | |
|------------------------------------------------|--------------------------------------------------|---------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Disturbing Thoughts | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Poor Concentration |
| <input type="checkbox"/> Alcohol Dependency | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Incompetent | <input type="checkbox"/> Recurring Thoughts |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Drug Dependence | <input type="checkbox"/> Inferior | <input type="checkbox"/> Regrets for Past |
| <input type="checkbox"/> Anti-Social | <input type="checkbox"/> Elevated Mood | <input type="checkbox"/> Internet Addiction | <input type="checkbox"/> Restless |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Empty Feelings | <input type="checkbox"/> Irritable | <input type="checkbox"/> Bullied |
| <input type="checkbox"/> Avoids People | <input type="checkbox"/> Evil | <input type="checkbox"/> Judgement Errors | |
| <input type="checkbox"/> Bad Home Environment | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Lonely | <input type="checkbox"/> Sick Often |
| <input type="checkbox"/> Bored | <input type="checkbox"/> Family Financial Issues | <input type="checkbox"/> Memory Problems | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Cannot Make Decisions | <input type="checkbox"/> Gaming Addiction | <input type="checkbox"/> Misunderstood | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Confused | <input type="checkbox"/> Guilty | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Thoughts of Self Harm |
| <input type="checkbox"/> Controlling | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Hateful | <input type="checkbox"/> Not Confident | <input type="checkbox"/> Unattractive |
| <input type="checkbox"/> Disorganized Thoughts | <input type="checkbox"/> Headaches | <input type="checkbox"/> Not Loved | <input type="checkbox"/> Withdrawing |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Worrying |
| <input type="checkbox"/> Distractible | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Phobias/Fears | <input type="checkbox"/> Worthless |

Please list your child's strengths and positive influences in his/her life:

Please describe your goals for child's counseling / things you would like for him/her to change about his/her life: