HopeLife Counseling

Healey E. Ikerd, MS, LPC, LMFT
PO Box 11051; Fayetteville AR 72703
479-202-4206

This information is kept confidential.

Date:_____

Child's Name: _____ D.O.B.: _____

Parent or Guardian Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Cell: _____

Is it okay to leave message on either of these? _____

Email: _____Is it okay to email you?_____

Age:_____ School:_____ Grade: _____

How does your child do in school academically? _____

How does your child do in school behaviorally?_____

Does your child have a learning or physical disability? __Y __ N __ Maybe Specify: _____

_____

Does your child have a mental health diagnosis? __Y __ N Specify: _____

_____

Does your family have a religious preference? _____

Do you want faith integrated into counseling? _____

Medical History

During pregnancy, did mother use: ___ Cigarettes ___ Alcohol ___ Drugs ___ Experience Extreme Stress? Specify frequency, amounts, and duration: _____

_____

List any birth complications (Ex: Premature, jaundice, C-section, etc.)_____

_____

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List any Medical conditions or history (Ex: Surgeries, broken bones, allergies, etc.): _____

_____

Does child use: ____ Cigarettes ____ Alcohol ____ Drugs / Specify amount/frequency:

_____

Primary Care Physician: _____ Last seen on: _____

Current medications: (Include dosage and frequency):_____

_____

Allergies: _____

In the first two years, did your child experience: __Separation from mother __Out of home __Disruption in bonding __Depression of mother __Abuse __ Neglect __Chronic pain __Chronic Illness __Parental Stress / If yes, please specify: _____

_____

Reached developmental milestones: ____ On time ____ Early ____ Late

Family History

Are father and mother married? __Y __ N If yes, for how long?_____

Does father work outside of the home? __Y __ N Occupation: _____

Does mother work outside of the home? __Y __ N Occupation: _____

Are parents separated or divorced? __ Y __ N If yes, when? _____

If separated or divorced, visitation schedule: _____

Does either parent have legal issues? _____

Please list Siblings' Name and Age: _____

_____

_____

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List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.): _____

_____

Have children witnessed domestic violence? __Y, __N, Specify: _____

_____

How is your child disciplined? Please list each method and frequency of use: _____

_____

Trauma History

Has your child been verbally abused? __Y, __N, __Suspected. Specify: _____

_____

Has your child been physically abused? __Y, __N, __Suspected. Specify: _____

_____

Has your child been sexually abused? __Y, __N, __Suspected. Specify: _____

_____

Other stressors or traumas? _____

_____

Share the symptoms your child displays and list the number of times per week symptom is displayed: _____

_____

_____

_____

How does your child handle anger? _____

_____

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Has the child experienced any significant loss? If yes, explain: _____

_____

What do you view as your child's major strengths and positive traits? _____

_____

What are your child's hobbies? _____

Briefly describe your goals for your child's therapy _____

_____

Please list any information you deem to be important for the therapist to know:

_____

_____

_____

_____

_____

_____