TAMMY JO VROOM, MSW
LICENSED CLINICAL SOCIAL WORKER

This form is information regarding the minor client (not the parent/guardian).

Date: _____ DOB: _____

Full Name: _____ SS#:_____

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

Phone #: _____ Alternative #: _____

Email: _____ Is it ok if I email you with information regarding your child's progress?

Parent/Guardian Information:

Name: _____ Relationship: _____

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

Phone #: _____ Alternative #: _____ Referral Source: _____

Does the above named person have legal joint custody with someone else?
If so, please indicate their information below:

Name: _____ Relationship to youth: _____

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

Others living in the home:

Name: _____ DOB: _____ School/Employer: _____

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Physical and Mental Health History: (please be accurate, records may need to be disclosed at some point)

General Health: Excellent Good Fair Poor Don't Know Comments:

Primary Care Physician: _____ Date of last visit: _____
Address: _____ Phone #: _____

Is this child currently under a physician's care of a psychiatrist? Yes No If yes, name of provider_____

Is this child currently taking medication? Yes No List of medications: _____

_____.

Allergies: _____ Adverse reactions to Medications: _____

Ever hospitalized for physical illness? Yes No Describe: _____

Ever hospitalized for mental illness? Yes No Describe: _____

Has this child ever used illegal drugs? Yes No Describe: _____

Has this child ever drank alcohol? Yes No Describe: _____

Has this child ever witnessed domestic violence or other types of violence? Yes No
Describe: _____

Has this child ever attempted or threatened suicide to harm him/herself? Yes No
Describe: _____

Has this child previously attended counseling/therapy? Yes No Describe: _____
IF YES
Name of Agency: _____ Counselor: _____ Dates seen: _____

Mother's health during pregnancy: Good Fair Poor Describe: _____

During the pregnancy; did the mother:
Take any medications: Yes No Please List: _____

Drink Alcohol? Yes No If yes, how much: _____

Smoke cigarettes? Yes No If yes, how much: _____

Recreational drugs? Yes No If yes, what/how much: _____

Education:

Is this child currently in school? Yes No Grade_____ Name of School: _____

Do they like school? Yes No Explain: _____
Favorite Classes: _____ Hardest Classes: _____

Does child get in trouble at school? Yes No If yes, please give details: _____

Does child avoid going to school? Yes No If yes, how often:_____

How often is the child absent from school? _____ If often, why? _____

How are the child's grades? _____ Comment: _____

Retained a grade? Yes No Which? _____ Skipped a grade Yes No Which? _____

Have an IEP or 504 Plan? Yes No Comment: _____

Has the child changed school for reasons other than normal academic progression? Yes No
If yes, when/why? _____

If child is not in school, please describe situation: _____

Stressors affecting your child: (Check all that apply)

_____Home _____Family

_____Peer _____Siblings/Step

____School _____Step Parent

____Parent Conflict _____Losses

Other: _____

Social History: (Check all that apply)

___Reading	___Math Problems	___Spelling Problems
___Writing Problems	___Other Learning problems	___Distractibility
___Not paying attention	___Disturbing other children	___Difficulty expressing self
___Loss of contact with reality	___Defiance toward authority	___Excessive talking
___Apparent intoxication	___Excessive fantasizing	___Repetitive behaviors
___Toileting problems	___Repeated violations at school	___Excessive anxiety
___Lack of motivation	___Difficulty following instructions	___Daydreaming
___Threatening other children	___Overreaction to discipline	___Excessive activity level
___Sex play with other children	___Bullied by others	___Seems unhappy most time
___Anger outbursts	___Easily frustrated	___Difficulty with friendships
___Difficulty with transitions	___Prefers to be alone	___Excessive fears/worries
___Sleep Problems	___Nervous habits	___Anxiety attacks

What does your child and family do for fun? (Check all that apply)

___Games ___Sports ___School functions ___Movies ___Other: _____

What are your child's assets? (Check all that apply)

___Academics ___Sports ___Plays well with others
___Music ___Helpful ___Cooperative
___Art ___Good Natured ___Other: _____

Other Information:

Religious Preference (if any): _____

Activities/Clubs: _____

Present Situation:

Why did you decide to bring your child for counseling/therapy? _____

_____

How long has this been a problem for them? _____

What would you like to get from counseling/therapy? _____

_____

Are there any legal issues going on with your family? If yes, please describe: _____

_____

Any additional information you would like to share? _____

_____

Personal agreement/consent to treat

I understand I may be asked to do certain "homework exercises" such as reading, changing behaviors and otherwise acting in my own best interest. I understand that I am entirely responsible for my own actions and I will always make my own final decisions regarding counseling. I further understand that much of the work done will be to resolve issues and will depend on my honesty and willingness to do the things I need to do to move forward even if it painful and difficult. I understand that whatever I say in the session is strictly confidential and will not be released to anyone without my consent unless I am violating codes of abuse, harm to others or myself. If I am a person under the age of 18, information may be given to my parents/guardian if necessary for my safety.

_____ _____ _____
Client's Signature Parent/Guardian Signature Date

I understand that missing three (3) appointments, without calling (no show/ no call) will result in my termination from Tammy Jo Vroom Counseling, LLC