CHILD Client information

Name of Child: ______________________________ DOB: __________Age:____

Parents: ______________________________

The Child is Currently Living With: ______________________ School and Grade: ______________

Extracurricular Activities/Interests: ______________________________

How would you describe your child's personality?______________________________

What are some of his/her strengths & challenges? ______________________________

Are both parents in agreement that this child needs counseling/support? ______YES ______NO

If parent/child and/or family therapy becomes necessary, are parents willing to participate? ______YES ______NO _______UNSURE

Medical History

How would you rate the child's current physical health? □ Excellent □ Good □ Fair □ Poor

Is the child currently complaining of any physical problems? If Yes, Please Explain: ______________________

____

Please list any medical conditions/disabilities/learning disabilities: ______________________

Daily Medication(s) Over the Counter or Prescription	Prescribing Physician

Pediatrician/Family Physician: ______________________ Phone: ______________

Counseling and Psychiatric History

Has the child had previous counseling? □ Yes □ No If yes, for how long? ______________ When? __________

For what reason? ______________________ Name of Counselor: ______________________

Has the child ever been diagnosed or treated for any type of mental illness? If yes, what type? ______________

Has anyone in the family ever been diagnosed with or treated for any type of mental illness? If yes, what type? __________

____

Reasons for Seeking Help

What concerns you most about your child? ______________________________

____

Where are these concerns causing the most problems for the child? □ Home □ School □ Social □ Other

When did these concerns begin to be a problem for the child? ______________________

What concerns about the child have been identified by others? ______________________

Please indicate which of the following are currently problems for the child:

□ Crying Spells
□ Excessive Fear/Anxiety
□ Bullying/Picking Fights
□ Hearing Voices
□ Lack of Motivation
□ Decreased/Increased Appetite
□ Difficulty Making or Keeping Friends
□ Obsessions/Compulsions
□ Cutting
□ Hyperactivity
□ Refusal to Respond to Authority
□ Nightmares
□ Difficulty Separating from Specific Family Members
□ Tantrums
□ Lack of Self-Confidence
□ Loss of Interest in Usual Activities
□ Insomnia/Hypersomnia

Is there anything else that you would like for me to know today? ____

____

____

Other information/Notes:

I give (counselor's name)____consent to work with my child

____in a therapeutic setting.

Parent(s) signature(s):____Date:_________________

Counselor's signature:____Date:_________________