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Today's Date: _____ **Person completing this form:** _____

A. Identification

1. Child's Full Name: _____

Gender: _____

Date of birth: _____ Age: _____ Social Security number: _____

Home address: _____

City: _____State: _____ Zip code: _____

Home phone: _____ Cell phone: _____

E-mail: _____

Please list any communication or texting restrictions: _____

_____

2. Mother's/Father's name: _____ Date of birth: _____ Age: __

Address: _____

City: _____State: _____ Zip code: _____

Home phone: _____ Cell phone: _____

Email address: _____ Currently employed: __ Yes __ No

Current employer: _____ Work phone: _____

3. Mother's/Father's name: _____ Date of birth: _____ Age: __

Address: _____

City: _____State: _____ Zip code: _____

Home phone: _____ Cell phone: _____

Email address: _____ Currently employed: __ Yes __ No

Current employer: _____ Work phone: _____

4. Parents are currently: __ Married __Partnered __Divorced __Remarried __Never married __Other; Child's custodian/guardian: _____

5. Stepparent's name: _____ Date of birth: _____ Age: ___
Address: _____
Home phone: _____ Cell phone: _____
Currently employed: __ Yes __ No
Current employer: _____ Work phone: _____

6. Stepparent's name: _____ Date of birth: _____ Age: ___
Address: _____
Home phone: _____ Cell phone: _____
Currently employed: __ Yes __ No
Current employer: _____ Work phone: _____

7. Custody Arrangements:

Mother: Sole Physical _____; Sole Legal _____
Joint Physical _____; Joint Legal _____

Father: Sole Physical _____; Sole Legal _____
Joint Physical _____; Joint Legal _____

B. Insurance

Primary Insurance

Responsible Party: _____
Employer: _____
Date Employed: _____
Social Security #: _____
Date of Birth: _____
ID Number: _____
Group ID Number: _____

Secondary Insurance

Responsible Party: _____
Employer: _____
Date Employed: _____
Social Security #: _____
Date of Birth: _____
ID Number: _____
Group ID Number: _____

C. Referral: Who gave you my name to call?

Name: _____ Phone: _____

D. Emergency Information

Emergency contact person: _____

Relationship: _____ Phone number: _____

E. Chief Concern

Please describe the main reason or difficulty for bringing your child to see me: _____

_____

_____

_____

F. Living Environment

List all people living in the home. Indicate which children are from a previous marriage or relationship with the letter P in the last column.

Name	Relationship	Date of birth	P

Children not living in the home:

Name	Relationship	Date of birth	P

G. Checklist of concerns

Please check how often the following behaviors occur. Those occurring frequently or of special concern may described on the next page.

Loses temper easily	___Never	___Rarely	___Sometimes	___Frequently
Argues with adults	___Never	___Rarely	___Sometimes	___Frequently
Refuses adults' requests	___Never	___Rarely	___Sometimes	___Frequently
Deliberately annoys people	___Never	___Rarely	___Sometimes	___Frequently
Blames others for own mistakes	___Never	___Rarely	___Sometimes	___Frequently
Easily annoyed by others	___Never	___Rarely	___Sometimes	___Frequently
Angry/resentful	___Never	___Rarely	___Sometimes	___Frequently
Spiteful/vindictive	___Never	___Rarely	___Sometimes	___Frequently
Defiant	___Never	___Rarely	___Sometimes	___Frequently
Bullies/intimidates/provokes/teases others	___Never	___Rarely	___Sometimes	___Frequently
Initiates fights	___Never	___Rarely	___Sometimes	___Frequently
Uses a weapon	___Never	___Rarely	___Sometimes	___Frequently
Physically cruel to animals	___ Never	___Rarely	___Sometimes	___Frequently
Physically cruel to people	___Never	___Rarely	___Sometimes	___Frequently
Stealing	___Never	___Rarely	___Sometimes	___Frequently
Forced sexual activity	___Never	___Rarely	___Sometimes	___Frequently
Intentional arson	___Never	___Rarely	___Sometimes	___Frequently
Burglary	___ Never	___Rarely	___Sometimes	___Frequently
Cons other people	___Never	___Rarely	___Sometimes	___Frequently
Runs away from home	___Never	___Rarely	___Sometimes	___Frequently
Truant, avoids school	___Never	___Rarely	___Sometimes	___Frequently
Doesn't pay attention to details	___Never	___Rarely	___Sometimes	___Frequently
Several careless mistakes	___ Never	___Rarely	___Sometimes	___Frequently
Does not listen when spoken to	___Never	___Rarely	___Sometimes	___Frequently
Doesn't finish chores/homework	___Never	___Rarely	___Sometimes	___Frequently
Difficulty organizing tasks	___Never	___Rarely	___Sometimes	___Frequently
Loses things	___Never	___Rarely	___Sometimes	___Frequently
Easily distracted	___Never	___Rarely	___Sometimes	___Frequently
Forgetful in daily activities	___Never	___Rarely	___Sometimes	___Frequently
Fidgety/squirmy	___Never	___Rarely	___Sometimes	___Frequently
Difficulty remaining seated	___Never	___Rarely	___Sometimes	___Frequently
Runs/climbs around excessively	___Never	___Rarely	___Sometimes	___Frequently
Difficulty playing quietly	___Never	___Rarely	___Sometimes	___Frequently
Hyperactive	___Never	___Rarely	___Sometimes	___Frequently
Difficulty awaiting turn	___Never	___Rarely	___Sometimes	___Frequently
Interrupts/talks out/yells	___Never	___Rarely	___Sometimes	___Frequently
Problems pronouncing words	___Never	___Rarely	___Sometimes	___Frequently
Poor grades in school	___Never	___Rarely	___Sometimes	___Frequently
Expelled from school	___Never	___Rarely	___Sometimes	___Frequently
Drug abuse	___Never	___Rarely	___Sometimes	___Frequently
Alcohol/substance use	___Never	___Rarely	___Sometimes	___Frequently
Depression/low mood/sadness	___Never	___Rarely	___Sometimes	___Frequently
Shy/avoidant/withdrawn	___Never	___Rarely	___Sometimes	___Frequently
Suicidal threats/attempts	___Never	___Rarely	___Sometimes	___Frequently
Fatigued	___Never	___Rarely	___Sometimes	___Frequently
Anxious/nervous	___Never	___Rarely	___Sometimes	___Frequently
Excessive worrying	___Never	___Rarely	___Sometimes	___Frequently
Sleep problems (too much, too little)	___Never	___Rarely	___Sometimes	___Frequently
Panic attacks	___Never	___Rarely	___Sometimes	___Frequently
Mood shifts	___Never	___Rarely	___Sometimes	___Frequently

Abuse (Current emotional, physical, sexual, verbal)	___Never	___Rarely	___Sometimes	___Frequently
Abuse (Past emotional, physical, sexual, verbal)	___Never	___Rarely	___Sometimes	___Frequently
Aggression/violence	___Never	___Rarely	___Sometimes	___Frequently
Alcohol/substance use of loved one	___Never	___Rarely	___Sometimes	___Frequently
Attention, concentration, distractibility	___Never	___Rarely	___Sometimes	___Frequently
Childhood issues (your own)	___Never	___Rarely	___Sometimes	___Frequently
Divorce, separation, remarriage (parents)	___Never	___Rarely	___Sometimes	___Frequently
Eating problems	___Never	___Rarely	___Sometimes	___Frequently
Failure in school	___Never	___Rarely	___Sometimes	___Frequently
Fighting/hitting/hostile/destructive	___Never	___Rarely	___Sometimes	___Frequently
Gambling	___Never	___Rarely	___Sometimes	___Frequently
Grieving/mourning/losses/deaths	___Never	___Rarely	___Sometimes	___Frequently
Health issues, medical concerns	___Never	___Rarely	___Sometimes	___Frequently
Impulsiveness/loss of control/outbursts	___Never	___Rarely	___Sometimes	___Frequently
Lack of respect for authority, insults, dares	___Never	___Rarely	___Sometimes	___Frequently
Learning disability/learning issues	___Never	___Rarely	___Sometimes	___Frequently
Low frustration tolerance/irritability	___Never	___Rarely	___Sometimes	___Frequently
Nightmare, night terrors	___Never	___Rarely	___Sometimes	___Frequently
Obsessive thinking/thoughts	___Never	___Rarely	___Sometimes	___Frequently
Oppositional/resists/refuses/doesn't comply	___Never	___Rarely	___Sometimes	___Frequently
Overactive/restless/hyperactive/fidgety	___Never	___Rarely	___Sometimes	___Frequently
Parenting/child management/single parent issues	___Never	___Rarely	___Sometimes	___Frequently
Pornography	___Never	___Rarely	___Sometimes	___Frequently
Recent move/new school/loss of friends	___Never	___Rarely	___Sometimes	___Frequently
Relationship problems (friends, relatives, siblings)	___Never	___Rarely	___Sometimes	___Frequently
Self-esteem	___Never	___Rarely	___Sometimes	___Frequently
Self-harm/self-injurious behaviors (cutting, head-banging, hitting self)	___Never	___Rarely	___Sometimes	___Frequently
	___Never	___Rarely	___Sometimes	___Frequently
Sexual issues (preoccupation, inappropriate sexual behaviors, sexual orientation, gender identity)	___Never	___Rarely	___Sometimes	___Frequently
Teased/bullied/victimized	___Never	___Rarely	___Sometimes	___Frequently
Temper problems/self-control issues	___Never	___Rarely	___Sometimes	___Frequently
Tics (involuntary rapid movements)	___Never	___Rarely	___Sometimes	___Frequently
Trauma survivor or witness	___Never	___Rarely	___Sometimes	___Frequently
Video gaming	___Never	___Rarely	___Sometimes	___Frequently
Weight and diet issues	___Never	___Rarely	___Sometimes	___Frequently
Wetting or soiling issues	___Never	___Rarely	___Sometimes	___Frequently
Withdraws from others, isolates	___Never	___Rarely	___Sometimes	___Frequently
Other	___Never	___Rarely	___Sometimes	___Frequently

H. Abuse History

Please list any emotional, physical or sexual abuse below. Use an E for Emotional, a P for physical and an S for sexual abuse.

Person who abused the child	Age(s) of abuse	Relationship to abuser	Type (E, P, or S)

I. Developmental History

1. Pregnancy and delivery

Prenatal medical illnesses and health care: _____

_____

Was your child premature? _____ Weight and height at birth: _____

Any birth complications or problems? _____

2. The first few months of life

Breast fed? ___ If so, for how long? _____

3. Developmental milestones: At what age did this child do each of these? If uncertain, indicate if within normal limits (WNL)

Sat without support: _____ Crawled: _____ Walked without holding on: _____

Helped when being dressed: _____ Ate with a fork: _____ Stayed dry all day: _____

Didn't soil pants: _____ Stayed dry all night: _____ Tied shoelaces: ____

Buttoned buttons: _____

4. Speech/language development

Age when child said first word understandable to a stranger: _____

Age when child said first sentence understandable to stranger: _____

Any speech, hearing or language difficulties? _____

_____

5. Sleep patterns or problems: _____

_____

6. Personality characteristics: _____

_____

J. Special skills or talents of child

List hobbies, sports, recreational musical, TV and toy preferences: etc.: _____

_____

_____

K. Health (Physical) History

1. Primary care doctor/clinic's name: _____

Phone: _____

Address: _____

_____

May I contact your child's medical doctor so that he or she can be fully informed, and we can coordinate treatment? ___ Yes ___No

2. List all of childhood illnesses, hospitalizations, medications, allergies, head injuries, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures and other medical conditions.

Condition	Age	Treated by whom?	Consequences

L. Mental Health/Counseling History

1. Has your child ever received psychiatric, drug or alcohol treatment, or counseling services before? ___ No ___Yes If yes, please indicate:

Date	Provider	Presenting Problem	Results

2. Has your child ever taken medications for psychiatric or emotional problems? __No __ Yes If yes, please indicate:

Date	Provider	Medications	Presenting Problem	Results

M. Schools

School (name, district, address, phone)	Grade	Teacher

May I call and discuss your child with the current teacher? ____Yes ____ No

N. Legal

1. Does the child have any current legal matters? __No __Yes

If yes, please explain: _____

_____

O. Other

Is there anything else I should know that does not appear on this form that may be helpful to our counseling sessions?

_____