**Patient Birth Name:** Click here to enter text. **Age:** Click here to enter text. **Date of Birth:** Click here to enter text. **Gender:** Choose an item. **Race:** Choose an item. **Religious/Spiritual Preference:** Choose an item.

For Office Use:

Appt Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
Appt Time: \_\_\_\_\_\_\_am/pm

Legal Guardian Name: Click here to enter text. Relation to patient: Click here to enter text.
 Signature of person completing form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

**PRESENTING CONCERNS***(Briefly outline areas of concern that have led to seeking out our services)*Click here to enter text.

Rate severity of above concerns **MOST SEVERE** [ ]  [ ] [ ] [ ] [ ] [ ] [ ]  **LEAST SEVERE**  1 2 3 4 5 6 7

Rate current ability to cope **UNABLE TO COPE** [ ]  [ ] [ ] [ ] [ ] [ ] [ ]  **COPES EASILY**  1 2 3 4 5 6 7

How long have these problems been causing distress?: [ ]  One Week [ ]  One Month [ ] 1-6 Months
 [ ] 6 Months to 1 year [ ] Longer than 1 year

**SYMPTOM IDENTIFICATION *(****please identify all**causing CURRENT concern, distress, or impairment of functioning****):*** *Sleep Pattern*: [ ]  Increased [ ]  Decreased [ ] Trouble Falling Asleep [ ] Trouble Staying Asleep [ ] Trouble Awakening

 *Appetite Pattern*: [ ]  Increased [ ]  Decreased *Concentration*: [ ]  Increased [ ]  Decreased [ ]  Excessive

 [ ] Suicidal Thoughts [ ] Self-Injurious Behaviors [ ] Paranoia/Hallucinations/Delusions [ ] Violence toward others

 [ ] Fire-Setting [ ] Stealing [ ] Truancy [ ] Poor Hygiene [ ] Poor social interaction [ ] Sexuality/Gender Concern

 [ ] Property Damage [ ] Substance Use [ ] Nightmares [ ] Running Away [ ] Impulsivity [ ] Reckless Behavior [ ] Grief

[ ]  Increased Anxiety (describe): Click here to enter text.

[ ]  Mood Swings (describe): Click here to enter text.

[ ]  Other Behavioral Changes (please describe): Click here to enter text.

**HISTORY OF TRAUMA**
[ ] Physical Abuse [ ] Sexual Abuse [ ] Psychological Abuse [ ] Neglect [ ] Domestic Violence [ ] Dating Violence
[ ] Assault/Battery [ ] Human Trafficking [ ] Victim of Robbery [ ] Loss of Loved One [ ] Car Wreck [ ] House Fire
[ ] Parental Divorce [ ] Bullying [ ] Parental Incarceration [ ] Natural Disaster Other: Click here to enter text.

F**AMILY COMPOSITION**  [ ]  Natural Born Child [ ]  Adopted [ ]  Foster Child

Mother’s Name: Click here to enter text. Age: Click here to enter text. Lives with child: [ ] Yes [ ]  No

 Occupation: Click here to enter text. Place of Employment: Click here to enter text.

Father’s Name: Click here to enter text. Age: Click here to enter text. Lives with child: [ ] Yes [ ]  No

Occupation: Click here to enter text. Place of Employment: Click here to enter text.

***Parent’s Marital Status:*** Choose an item. ***Child Custody Status:*** Choose an item.

*Please list all immediate family members below (siblings, step parents, step siblings, half siblings, etc.) Please include all individuals residing in the child’s place of residence.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Gender | Age | Relationship to Child | Living with Child? |
| Click here to enter text. | Choose an item. | Text | Text | [ ] Yes [ ]  No |
| Click here to enter text. | Choose an item. | Text | Text | [ ] Yes [ ]  No |
| Click here to enter text. | Choose an item. | Text | Text | [ ] Yes [ ]  No |
| Click here to enter text. | Choose an item. | Text | Text | [ ] Yes [ ]  No |
| Click here to enter text. | Choose an item. | Text | Text | [ ] Yes [ ]  No |
| Click here to enter text. | Choose an item. | Text | Text | [ ] Yes [ ]  No |
| Click here to enter text. | Choose an item. | Text | Text | [ ] Yes [ ]  No |
| Click here to enter text. | Choose an item. | Text | Text | [ ] Yes [ ]  No |
| Click here to enter text. | Choose an item. | Text | Text | [ ] Yes [ ]  No |

What other family dynamics do you feel may help the therapist better understand the patient’s needs? Examples include strained relationships, lack of contact with biological relatives, adoption status, etc.
Click here to enter text.

Describe parenting your child: [ ]  Easy [ ]  Moderate [ ]  Challenging

What do you find most challenging in parenting the child? Click here to enter text.

What kind of discipline does your child respond well to? Click here to enter text.

**EDUCATION**Is your child currently enrolled in school? [ ]  Yes [ ] No Name of School: Click here to enter text. Grade: Choose an item.

Describe child’s attitude towards school [ ]  Interested [ ]  Indifferent [ ]  Disinterested

Describe child’s academic performance [ ]  Poor [ ]  Fair [ ]  Exceptional

Describe child’s attendance: [ ]  Attends Regularly [ ]  Some Truancy [ ]  Often Truant [ ]  Dropped Out [ ]  Home Bound

Does your child have a history of behavioral issues or discipline at school? [ ] Yes [ ] No
If yes: please explain: Click here to enter text.

Does your child have either of these accommodations? [ ] IEP [ ] 504 Plan [ ] Not Applicable [ ] Seeking out

Does your child receive any specialty services at school? (speech, counseling, etc.) [ ] Yes [ ] No

Please list any known learning deficits or disabilities? Click here to enter text.

History of bullying? [ ] Yes [ ] No If yes, please describe: Click here to enter text.

**DEVELOPMENTAL HISTORY**

[ ]  Full Term Birth [ ]  Premature Birth Birth Weight: Text pounds Text ounces

How long was the hospital stay for the birth? Click here to enter text.

Were there any complications during pregnancy? [ ] Yes [ ]  No If yes, please explain Click here to enter text.

Were there any complications during birth? [ ] Yes [ ]  No If yes, please explain Click here to enter text.

Was the child exposed to any alcohol to drug use during the pregnancy? [ ] Yes [ ]  No
 If so, please explain: Click here to enter text.

How old was your child when he/she:
 Rolled Over: Text Crawled: Text Walked: Text Talked (2 words): Text Potty Trained: Text

Have there been any past concerns involving your child as related to the following developmental areas?
[ ]  Speech/Language [ ]  Motor Skills [ ] Cognitive/Intellectual [ ] Sensory [ ] Behavioral [ ] Emotional [ ] Social [ ] Attachment

If so, please describe: Click here to enter text.

Were there any significant disturbances in patient’s childhood? [ ] Yes [ ]  No

If yes, Please describe: Click here to enter text.

**HEALTH HISTORY**

How would you describe your child’s overall health? [ ] Poor [ ] Fair [ ] Healthy
Does your child have a history of health issues? [ ] Yes [ ]  No
Does your child have any recurrent health issues (ear infections, allergies, asthma, etc). [ ] Yes [ ]  No

|  |  |  |  |
| --- | --- | --- | --- |
| Medical Condition | Receiving Treatment | Medical Provider | Impairs current functioning? |
| Click here to enter text. | [ ] Yes [ ]  No | Click here to enter text. | [ ] Yes [ ]  No |
| Click here to enter text. | [ ] Yes [ ]  No | Click here to enter text. | [ ] Yes [ ]  No |
| Click here to enter text. | [ ] Yes [ ]  No | Click here to enter text. | [ ] Yes [ ]  No |
| Click here to enter text. | [ ] Yes [ ]  No | Click here to enter text. | [ ] Yes [ ]  No |
| Click here to enter text. | [ ] Yes [ ]  No | Click here to enter text. | [ ] Yes [ ]  No |

Has your child ever had a serious illness/accident and required hospitalization? [ ] Yes [ ] No

|  |  |
| --- | --- |
| Reason For Hospitalization | Approximate Date and Location of Hospitalization |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication Name | Dose | Frequency | Prescribed By | Reason for Medication |
| Click here to enter text. | Text | Text | Text | Click here to enter text. |
| Click here to enter text. | Text | Text | Text | Click here to enter text. |
| Click here to enter text. | Text | Text | Text | Click here to enter text. |
| Click here to enter text. | Text | Text | Text | Click here to enter text. |
| Click here to enter text. | Text | Text | Text | Click here to enter text. |

 **CURRENT MEDICATIONS** (Please list all) [ ]  My child does not take any medications

Is your child currently taking all medications as prescribed? [ ]  Yes [ ] No If no, please explain: Click here to enter text.

Has your child had recent screenings with any of the following types of providers?

 [ ] Dentist Provider Name: Click here to enter text.
[ ] Eye Doctor Provider Name:Click here to enter text.
 [ ] Chiropractor Provider Name: Click here to enter text.
 [ ] Speech Language Pathologist Provider Name: Click here to enter text.

**MENTAL HEALTH HISTORY**

Has your child previously been diagnosed with any mental health conditions? [ ] Yes [ ]  No

If so, please list prior diagnoses: Click here to enter text.

*Please list all current and past outpatient mental health providers below (counselors, psychiatrists, etc.):*

|  |  |  |  |
| --- | --- | --- | --- |
| Provider/Agency Name | Dates of Service | Reason for Treatment | Current Provider? |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | [ ]  Yes [ ]  No |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | [ ]  Yes [ ]  No |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | [ ]  Yes [ ]  No |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | [ ]  Yes [ ]  No |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | [ ]  Yes [ ]  No |

Has your child ever been hospitalized due to a mental health crisis? [ ]  Yes [ ]  No

Please list any prior inpatient/residential psychiatric admissions below:

|  |  |  |
| --- | --- | --- |
| Location (Hospital Name) | Approximate Date/Length of Stay | Reason for admission |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |

Has your child ever made threats to harm self or end his/her life? [ ]  Yes [ ]  No

Has your child ever acted on thoughts of self-harm? [ ]  Yes [ ]  No If yes, how? Click here to enter text.

Has your child ever made threats to harm others? [ ]  Yes [ ]  No

Has your child ever acted on thoughts to harm others? [ ]  Yes [ ]  No If yes, how? Click here to enter text.

Is there a family history of suicide? [ ]  Yes [ ]  No If yes, who? Click here to enter text.

Additional Info Regarding History of Safety Concerns:
Click here to enter text.

**SUBSTANCE ABUSE HISTORY**
Does or has your child ever used tobacco, smokeless tobacco, or a vape? [ ] Yes [ ] No

Does your child have a history of illicit drug and/or alcohol use? [ ] Yes [ ] No If yes, list known drug use below:
Click here to enter text.

Has your child’s use of alcohol or drugs resulted in impairment in any of the following areas:
[ ] Legal [ ]  Social [ ]  Employment [ ]  Family [ ] Relational [ ]  Financial

Has your child ever overdosed or passed out as the result of substance use? [ ] Yes [ ] No

Has your child ever received any inpatient or outpatient substance abuse treatment? [ ] Yes [ ] No

**LEGAL INVOLVMENT**Has the child ever been involved with Child Protective Services? [ ] Yes [ ] No If so, when? Click here to enter text.

Was the child ever in foster care? [ ] Yes [ ] No If so, when? Click here to enter text. [ ] Relative [ ] Non-Relative Placement

Is the child/family currently involved in an open case plan or investigation with Child Protective Services? [ ] Yes [ ] No

Has the child ever been involved with the criminal justice system (juvenile or adult court)? [ ] Yes [ ] No
 If so, select current status: [ ]  No current legal status [ ] On Probation [ ]  On Parole [ ]  Charges Pending
 [ ]  Prior Incarceration
 Probation/Parole Officer Name: Click here to enter text.
Please provide details on child’s current or past legal history (as applicable):
Click here to enter text.

**HOUSING**Would you consider current living arrangements to be: [ ] Stable [ ] Unstable

Please choose the below which one describes current living arrangement:
[ ] Parent Guardian owns home [ ] Parent/Guardian rents home [ ] Child/Family temporarily live with relatives/friends
[ ] Child/family permanently live with relatives/friends [ ] Homeless [ ] Emergency Shelter [ ] Transitional Housing

How long has child lived in the current living situation? Click here to enter text.

How many times has the child moved in the last 2 years? Click here to enter text.

Additional details on living situation: Click here to enter text.

**EMPLOYMENT**Is your child employed? [ ] Yes [ ] No If so, where? Click here to enter text. Length of Employment: Click here to enter text.
 Does the child enjoy their job? [ ] Yes [ ] No

**FAMILY HISTORY OF MENTAL HEALTH**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Kinship | Depression | Anxiety | Bipolar | Schizophrenia | ADHD | Trauma | Alcohol Use | Drug Use | Incarceration |
| Mother |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Father |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Brother |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Sister |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Uncle |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Aunt |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Grandmother |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Grandfather |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Click here to enter text. |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Click here to enter text. |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Click here to enter text. |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Click here to enter text. |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

**GOALS AND NEEDS**What do you feel is the child’s current biggest need? Click here to enter text.
What do you most hope for the child to gain from counseling? Click here to enter text.

Please identify up to three goals that you feel we can address in therapy:

*Goal 1*: Click here to enter text.
*Goal 2:* Click here to enter text.
*Goal 3*: Click here to enter text.

**MISCELLANEOUS CONCERNS/INFORMATION (if applicable)**
Click here to enter text.