**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.