



- Victimization** (*please circle*):      Physical abuse              Sexual abuse              Elder abuse
- Adult molested as child              Robbery victim              Assault victim              Dating violence
- Domestic Violence      Human trafficking              DUI/DWI crash              Survivors of homicide victims
- Other: \_\_\_\_\_

**Other** (*Please describe other concerns*):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**How long has this problem been causing your child distress?** (*please circle*)

- One week      One month      1-6 Months      6 Months-1 Year      Longer than one year

**How do you rate your child's current level of coping on a scale of 1 -10** (with 1 being unable to cope)?

UNABLE TO COPE    1    2    3    4    5    6    7    8    9    10    ABLE TO COPE

**FAMILY COMPOSITION**

**Mother's name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

- Living with child    · Not living with child    Employed Currently?    · Yes    · No

**Place of Employment:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

- Living with child    · Not living with child    Employed Currently?    · Yes    · No

**Place of Employment:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Marital status of Parents:**    · Single    · Married    · Divorced    · Widowed    · Domestic Partnership

*Please list the names, ages, relationships and other relevant information regarding all immediate family members whether living in- or outside the home. Please include all members currently residing in child's household.*

Name	Gender	Age	Relationship to Client	Living With Child
_____				· Yes · No
_____				· Yes · No
_____				· Yes · No
_____				· Yes · No
_____				· Yes · No
_____				· Yes · No
_____				· Yes · No

**What else do you feel/believe would be helpful, or important for us to know/understand about your relationships with your family or about your family members?**

\_\_\_\_\_

**RECENT LOSSES**

Family Member    Friend    Health    Lifestyle    Job    Income    Housing    None  
Who? \_\_\_\_\_ When? \_\_\_\_\_ Nature of Loss? \_\_\_\_\_

Other Losses: \_\_\_\_\_

**Additional information (if needed):**

\_\_\_\_\_  
\_\_\_\_\_

**PREGNANCY & BIRTH HISTORY**

**Were there any complications during pregnancy?**    Yes    No   If yes, please explain:

\_\_\_\_\_

Full-term Birth    Premature Birth

**Were drugs or alcohol consumed during pregnancy?**    Yes    No

**Child's weight at birth?** \_\_\_\_\_ lbs. \_\_\_\_\_ oz. **Child's health at birth?** \_\_\_\_\_

**Length of hospital stay?** \_\_\_\_\_ **Post-partum depression?**  Yes  No

**Was your child adopted?**    Yes    No   If yes, at what age? \_\_\_\_\_

Domestic adoption    International adoption (Country: \_\_\_\_\_)

**DEVELOPMENTAL HISTORY**

**As accurately as you can remember, how old was your child when she/he:**

**Rolled over?** \_\_\_\_\_ **Crawled?** \_\_\_\_\_ **Walked?** \_\_\_\_\_ **Talked (two words)?** \_\_\_\_\_ **Toilet Trained?** \_\_\_\_\_

**Do/did you have concerns about your child's development in any of these areas (below)?**

Speech/Language    Motor Skills    Cognitive/Intellectual    Sensory    Behavioral    Emotional    Social

If so, please describe: \_\_\_\_\_

\_\_\_\_\_

**Were there any significant disturbances/changes during your child's childhood?**    Yes    No

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HEALTH HISTORY**

**How would you describe your child's overall health?** \_\_\_\_\_

**Does your child have any health issues?**    Yes    No   If yes, please list below:

\_\_\_\_\_

**Does your child have any recurrent medical conditions such as ear infections, asthma or allergies?**    Yes    No

If yes, please explain: \_\_\_\_\_

*Please list below current medical problems, physical limitations, sleep problems, unusual eating habits, poor hygiene, overall physical fitness, head injuries, early childhood infections, eating disorders, knee or back injuries, asthma, etc.*

Medical Conditions	Currently receiving treatment?	Provider	Does this condition cause stress or impairment at this time?	What have you found that helps?

Does your child currently take any medications?    Yes    No

*Please list medications (including psychotropic, over-the-counter, herbal remedies) that you have taken in the past 6 months*

Medication	Dosage	Frequency	Prescribed By	Reason for Medication

*Has your child ever had a serious accident/illness or hospitalization?*    Yes    No

*Please list all past hospitalizations, surgeries, accidents, or illnesses in the chart below.*

Reason for Previous Hospitalizations, Accident, Illness	Date/Location of Hospitalization

Primary Care Doctor: \_\_\_\_\_ Facility: \_\_\_\_\_ Phone#: \_\_\_\_\_

**PSYCHIATRIC/PSYCHOLOGICAL HISTORY**

Is your child currently being seen by a psychiatrist?  Yes  No

If yes, name of current psychiatrist \_\_\_\_\_ Length of Treatment \_\_\_\_\_

Has your child ever been diagnosed with a mental health, emotional or psychological condition?

Yes  No

If yes, what diagnosis were your child given?

\_\_\_\_\_

When? \_\_\_\_\_

By Whom? \_\_\_\_\_

Has your child received counseling services or been hospitalized for mental health or drug and alcohol concerns in the past?

Yes  No

*If yes, please list previous counseling/hospitalizations for mental health/drug and alcohol concerns below*

Dates of Service	Place/Provider	Reason for treatment	Were the services helpful

**SAFETY CONCERNS**

Is your child presently suicidal?  Yes  No

If Yes, please explain

\_\_\_\_\_

Has your child ever attempted to commit suicide?  Yes  No

If yes, when and how?

\_\_\_\_\_

Is there a history of suicide in your child's immediate and/or extended family?  Yes  No

If yes, please explain:

\_\_\_\_\_

Is your child presently homicidal?  Yes  No

If Yes, please explain \_\_\_\_\_

**CURRENT FUNCTIONING**

Do you have concerns about your child in the following areas? (check all that apply)

- Eating
- Hygiene/grooming
- Sleeping
- Activities/play
- Social Relationships

If so, please describe: \_\_\_\_\_

Please rate your child's personality/temperament (how they behave the majority of the time in each of the following areas on a scale from 1 to 7 by placing a check above the number that best describes your child):

**ENERGY/ACTIVITY LEVEL** (how active is my child?)

**CAN** sit still and listen for long periods of time

\_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_  
 1    2    3    4    5    6    7

**CAN'T** sit still and listen for long periods of time

**NEED FOR PHYSICAL ROUTINE** (how much routine does my child need?)

**ENJOYS ROUTINE**; easily upset when day doesn't go as usual

\_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_  
 1    2    3    4    5    6    7

**ENJOYS DOING THINGS DIFFERENTLY**; may not notice small changes in the day

**MOOD** (what is my child's mood most of the time?)

**ANXIOUS**-usually frustrated and worried

\_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_  
 1    2    3    4    5    6    7

**CALM**-usually relaxed

**HAPPY**-usually enjoys what he/she is doing

\_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_  
 1    2    3    4    5    6    7

**SAD**-usually unhappy; hard time having fun

**CURIOUS**-usually eager to know something

\_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_  
 1    2    3    4    5    6    7

**TIMID**-usually not interested

**ANGRY**-easily frustrated and annoyed with others

\_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_  
 1    2    3    4    5    6    7

**CALM**-usually composed and peaceful with others

**INTENSITY** (how strongly does my child express feelings, wants and opinions?)

**MILD REACTION**-calm And cooperative; Easily pushed around by others

\_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_  
 1    2    3    4    5    6    7

**STRONG REACTION** may cry or yell over small things

**PERSISTENCE** (Can my child stick with and complete tasks?)

**Will stick with something** until it is done

\_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_ : \_\_\_\_  
 1    2    3    4    5    6    7

**Gives up on tasks**; has trouble finishing things

**SENSITIVITY TO SENSES** (How sensitive is my child to light, smells, sounds, and touching?)

Learns by seeing touching and using all his/her senses

\_\_\_\_: \_\_\_\_: \_\_\_\_: \_\_\_\_: \_\_\_\_: \_\_\_\_: \_\_\_\_  
1 2 3 4 5 6 7

Has strong reaction to noise, lights, hugging or touching

**PERCEPTIVENESS** (How aware is my child of feelings and emotions?)

Sympathetic to others; can use words to tell how he/she feels

\_\_\_\_: \_\_\_\_: \_\_\_\_: \_\_\_\_: \_\_\_\_: \_\_\_\_: \_\_\_\_  
1 2 3 4 5 6 7

Unaware of the feelings of others

**ADAPTABILITY** (How easily does my child accept changes?)

Often fearful with new people and new situations

\_\_\_\_: \_\_\_\_: \_\_\_\_: \_\_\_\_: \_\_\_\_: \_\_\_\_: \_\_\_\_  
1 2 3 4 5 6 7

Will easily meet and accept new people and activities

**ATTENTION SPAN/DISTRACTIBILITY** (How well does my child pay attention?)

Stays focused on tasks until completed

\_\_\_\_: \_\_\_\_: \_\_\_\_: \_\_\_\_: \_\_\_\_: \_\_\_\_: \_\_\_\_  
1 2 3 4 5 6 7

Easily sidetracked; difficulty following directions

**PARENT/CHILD RELATIONSHIP**

Describe parenting your child (e.g. challenging, easy): \_\_\_\_\_

What do you find most challenging in parenting your child? \_\_\_\_\_

What kind of discipline works best with your child? \_\_\_\_\_

**EDUCATION**

Is your child currently enrolled in school?  Yes  No Name of School: \_\_\_\_\_

What grade is your child currently in (if summer, was grade is your child going into)? \_\_\_\_\_

How would you describe your child's attendance (currently)? (circle ALL that apply)

- Attending regularly      Home-schooled      Some truancy      Alternative school      Suspended
- Expelled      Dropped Out      GED program

How would you describe your child's achievement/grades in school? \_\_\_\_\_

How would you describe your child's attitude towards school/education? \_\_\_\_\_

Disciplinary or behavioral issues at school?  Yes  No If yes, describe: \_\_\_\_\_

**Please check if your child has any of the following?**

- Special Education Accommodations or a 504? Please describe: \_\_\_\_\_
- An Individualized Education Plan (IEP)? Please describe: \_\_\_\_\_
- Diagnosed Learning Disability? Please describe: \_\_\_\_\_
- Receiving special services at school? Please describe: \_\_\_\_\_

**EMPLOYMENT**

Is your child currently employed?  Yes  No

If employed, where are they working? \_\_\_\_\_ How long? \_\_\_\_\_

Does your child enjoy their current job?  Yes  No

**HOUSING**

**Would you consider your housing to be:**     stable     unstable

If unstable, please describe:

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**Please choose the one that best describes the current housing arrangement for this child:**

- Parent/Guardian owns home
- Parent/Guardian rents home
- Child and family live with relatives/friends (temporary)
- Child and family live with relatives/friends (permanent)
- Homeless     Transitional Housing     Emergency Shelter

**How long has this child lived in the current living situation?** \_\_\_\_\_

**How many times has the child moved in the past two years?** \_\_\_\_\_

**What else do you think is important for us to understand about your housing/living situation?**

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**FOSTER CARE INVOLVEMENT**

**Have your child ever been in foster care?**     Yes     No     Unknown

From \_\_\_\_\_ age to \_\_\_\_\_ age

**Reason:** \_\_\_\_\_

**Placement Type:**     Familial Placement     Non-Familial Placement

**Current Status:**     In-Care     Out of Care

**If Out of Care, reason for leaving:**     Adopted     Returned to Home     Emancipated

Ran away from care     Other: \_\_\_\_\_



**FAMILY MENTAL HEALTH HISTORY**

*Please identify if any members of your family have had a history of any of the following mental health/drug abuse/legal concerns*

Family History	Depression	Anxiety	Bipolar Disorder	Schizophrenia	ADHD/ADD	Trauma History	Abusive Behavior	Alcohol Abuse	Drug Abuse	Incarceration
Self										
Mother										
Father										
Sister										
Brother										
Maternal Uncle										
Paternal Uncle										
Maternal Aunt										
Paternal Aunt										
Maternal Grandmother										
Paternal Grandmother										
Maternal Grandfather										
Paternal Grandfather										

**ALCOHOL/DRUG ASSESSMENT**

**Does your child use tobacco or smokeless tobacco?**  Yes  No  Do not know

**Does your child use alcohol or drugs?**  Yes  No  Do not know

**To your knowledge, has your child ever used medications (prescriptions drugs or over the counter medication) recreationally?**  Yes  No  Do not know

**To your knowledge, has your child ever overdosed or passed out on alcohol or other drugs?**

Yes  No If yes, when was the last overdose? \_\_\_\_\_

**Has your child ever experienced problems related to their alcohol use?**  Yes  No

**If yes, please check area and describe problems:**

Legal  Social/Peer  Work  Family  Friends  Financial

Please describe: \_\_\_\_\_

**If yes, have they continued to drink/use drugs?**  Yes  No

**LEGAL INVOLVEMENT**

Is there a current custody case involving your child?  Yes  No If yes, please describe below.

History of CPS involvement:  None  Past  Current Please describe below.

Please indicate by checking your child’s legal status below.

- No Involvement  No Involvement  Probation | Length: \_\_\_\_\_
- Parole | Length: \_\_\_\_\_  Charges Pending  Prior Incarceration
- Law Suit or other Court Proceeding

Charges: \_\_\_\_\_ Probation/Parole Officer’s Name: \_\_\_\_\_

Contact #: \_\_\_\_\_

Additional Information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HISTORY OF ABUSE/NEGLECT**

Has your child ever been abused or assaulted?  Yes  No If Yes, please complete the chart below.

Type of Abuse	By Whom?	At What Age?	Was it Reported?
<input type="checkbox"/> Sexual			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Physical			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Emotional			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Verbal			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Abandoned/Neglected			<input type="checkbox"/> Yes <input type="checkbox"/> No

Has your child ever been a victim of bullying?  Yes  No

Do you worry about your child safety?  Yes  No

What else do you feel is important for us to know?

\_\_\_\_\_

**HISTORY OF VIOLENCE**

Has your child ever been accused of abusing or assaulting someone?  Yes  No If yes, please complete chart below.

Type of Abuse	To Whom?	At What Age?	Was it Reported?
<input type="checkbox"/> Sexual			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Physical			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Emotional			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Verbal			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Abandoned/Neglected			<input type="checkbox"/> Yes <input type="checkbox"/> No

Has your child ever been known to bully other children?  Yes  No

What else do you feel/believe is important for us to know?

\_\_\_\_\_

**STRENGTHS/RESOURCES/SUPPORTS**

What limitations does your child/family have (if any)?

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What strengths does your child/family have?

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What resources does your child have to help with your current problem?

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What experiences (past & present) will help you in improving the current situation?

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What are you (and your family) already doing to improve the current situation?

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Who can you count on for support?  Parents  Boyfriend/Girlfriend  Siblings  Pastor

Extended Family  Friends  Neighbors  School Staff  Church  Therapist  Group

Community Services  Doctor  Other: \_\_\_\_\_

**CURRENT NEEDS/GOALS**

What do you feel is your child's biggest need right now?

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What do you most hope to gain from coming to counseling?

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If you were to pick three goals to work on, what would they be?

Goal 1:

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Goal 2:

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Goal 3:

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