Client Name: _____
File # _____

COUNSELING

New Client Form (Child)

Date _____

Instructions: Please complete this form to the best of your ability with the information you have available to you at this time. Do your best to answer each item as fully as you can. ***It is highly recommended that this form be completed with information developed in cooperation with the child, if possible.***

General Client Information

Child's Name _____ Gender:_____ Age: _____ DOB: _____

Parent/Guardian Name: _____ Relationship: _____

Address _____ City: _____ State: _____ Zip code: _____

Parent/Guardian Home Phone: _____ Parent/Guardian Work Phone: _____

Parent/Guardian Cell: _____ Email address: _____

May we contact you via: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email (email is non-secure) ☐

Other:_____ May we leave a Voice Message? ☐ YES ☐ NO

Other Emergency Contact:_____ Relationship: _____ Phone: _____

Child's Place of Birth: _____Ethnic/Cultural Background:_____Religion: _____

Native Language: _____ School: _____Grade:_____

Parent/Guardian Occupation: _____ Annual Income: _____ Employer: _____

Referred by: _____May I thank this referral source for directing you to this practice? ☐ Yes ☐ No

Health Insurance Information

Insurance Company:_____ Policy #: _____ Group #: _____ Co Pay:_____

Name of Subscriber:_____Date of Birth of Subscriber: _____ Relation to Client: _____

Place of Employment of Subscriber: _____

Current Issues

Please provide a brief description of why you are seeking counseling/therapy services for your child:

- Has anything happened that may have brought on/intensified your child's problems? ☐ Yes ☐ No

If yes, please explain:

_____

- When (month/year) did your child first begin to experience these problems? _____
- How many days, weeks, months, or years has your child been experiencing these problems?

_____

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- How often does your child experience these problems? (check the one that best describes your child's current experience).
  - ❑ Most of the day, every day
  - ❑ Some part of the day, every day
  - ❑ Most of the day on most days
  - ❑ Some part of the day on most days
  - ❑ More than once a week
  - ❑ More than once a month
- How much is/are the problems affecting your child? ☐ Mildly ☐ Moderately ☐ Severely
- In what areas do your child's problems impact his/her life? (Check all that apply)
  - ☐ Lifestyle (the way your child lives his/her life)
  - ☐ Activities (things your child normally does or would like to do)
  - ☐ Relationships (your child's ability to form or maintain relationships with others)
  - ☐ Eating
  - ☐ Sleeping
  - ☐ Mood
- Has your child ever attempted suicide? ☐ Yes ☐ No If yes, when? _____
- Has your child been thinking about suicide? ☐ Yes ☐ No
- Has your child ever thought about harming or killing someone else? ☐ Yes ☐ No If yes, when? _____

  Has your child been thinking about harming or killing someone else? ☐ Yes ☐ No

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Child Problems Checklist: Check all that apply (to be completed by both the child and parent/guardian)

- ❑ Depression
- ❑ Low energy
- ❑ Low self-esteem
- ❑ Poor concentration
- ❑ Lack of interest/enjoyment in life
- ❑ Feeling hopeless
- ❑ Feeling worthless
- ❑ Feeling guilty or shameful
- ❑ Sleep changes (more/less)
- ❑ Loneliness
- ❑ Bad dreams/nightmares
- ❑ Feeling Ignored or abandoned
- ❑ Appetite changes (more/less)
- ❑ Mood swings
- ❑ Thoughts of hurting self
- ❑ Thoughts of hurting others
- ❑ Isolating from others/social withdrawal
- ❑ Feelings of sadness/loss
- ❑ Weight problems
- ❑ Stress
- ❑ Anxiety/tension/worry
- ❑ Panic attacks
- ❑ Heart racing
- ❑ Chest pain or heaviness
- ❑ Chills/hot flashes
- ❑ Tingling/numbness
- ❑ Pain
- ❑ Fear of dying
- ❑ Fear of going "crazy"
- ❑ Nausea
- ❑ Fears or phobias
- ❑ Obsessions/compulsions
- ❑ Thoughts racing
- ❑ Disorganization
- ❑ Procrastination
- ❑ Can't hold onto an idea
- ❑ Anger/frustration
- ❑ Suspiciousness or mistrustfulness
- ❑ Problems trusting others
- ❑ Easily irritated/annoyed
- ❑ Aggressiveness
- ❑ Perfectionist behavior
- ❑ Lying
- ❑ Making/keeping friends
- ❑ Arguing with others
- ❑ Performing unusual rituals or habits
- ❑ Impulsiveness
- ❑ Excessive behaviors (Examples: spending, gambling)
- ❑ Delusions/hallucinations (Thinking/believing or seeing/hearing unusual things)
- ❑ Sexual problems/behavior
- ❑ Self injurious behaviors
- ❑ Shyness
- ❑ Social skills
- ❑ Social support (family/friends)
- ❑ Stealing
- ❑ Strange, weird, or peculiar behavior
- ❑ Confusion/can't think clearly
- ❑ Feeling "not real"
- ❑ Feeling detached from yourself
- ❑ Feeling "hyper"
- ❑ Financial problems
- ❑ Grief/bereavement
- ❑ Health problems
- ❑ Impact of your problems on others
- ❑ Losing track of time
- ❑ Problems with memory
- ❑ Unpleasant thoughts that won't go away
- ❑ Bothered by recurring thoughts
- ❑ school/educational problems or indecision
- ❑ Destruction of property
- ❑ Self-criticism
- ❑ Family problems
- ❑ Marital/relationship problems
- ❑ Parent/child problems
- ❑ Use of alcohol
- ❑ Use of drugs
- ❑ Blackouts
- ❑ Physical abuse
- ❑ Sexual abuse
- ❑ Partner abuse
- ❑ Trouble with the law
- ❑ Experienced/witnessed trauma
- ❑ Loss/death of someone close
- ❑ Impulsive behaviors
- ❑ Other (please describe):

Impact of Child's Problem on Family: (to be completed by parent or guardian)

Child's Name: _____ File # _____ Date: _____

Person completing checklist: _____

Rating Scale
Read each of the items below. Write in the number that corresponds with the level of impact your child's problem has in each area.

0 ***No impact in this area***
1 ***Slight impact in this area***
2 ***More than slight impact, but less than moderate impact***
3 ***Moderate impact***
4 ***More than moderate impact***
5 ***Serious impact***

Hope & Healing

Client Name: _____
File # _____

COUNSELING

Areas of Family Life

	1. Time mother spends with the other children in the family		11. Visiting friends in their homes
	2. Time father spends with the other children in the family		12. Emotional well-being of mother
	3. Amount of time mother spends with father		13. Emotional well-being of father
	4. Amount of time father spends with mother		14. Emotional well-being of brother(s) and sister(s)
	5. Family time spent with relatives		15. Family finances
	6. Going out to eat as a family		16. Relationship between parents
	7. Going out as a family other than to eat (e.g., shopping, church, movies)		17. Relationships among the children of the family
	8. Going on a family vacation		18. Relationship between patient and parents
	9. Having friends visit our home		19. Relationship between parents and the other children of the family
	10. Mealtimes		20. Spending leisure time together

Current Life Experiences

- My child lives in: ☐ Apartment ☐ House ☐ Condo/Townhouse ☐ Mobile Home ☐ Rooming House ☐ Other
- My child lives with:

Name Age Relationship to child Problems

_____

_____

_____

- Other significant persons in my child's life who do not live with him/her include:

Name Age Relationship to me Problems Resides where?

_____

_____

_____

Problems or changes in my child's family or other important interpersonal relationships:

Date(s) Persons Involved Relationship to me Problems or Changes

_____

_____

_____

Client Name: _____
File # _____

COUNSELING

Problems or changes in educational, social, or recreational functioning:

Date(s) Problems or Changes

_____

_____

_____

My child's sources of satisfaction:

_____

- My child's sources of stress:

  _____

- My child's leisure activities:

  _____

- My child's typical day is as follows (attach extra sheets, if necessary):

- History of Counseling or /Therapy:

- Is your child currently being treated by a counselor, psychologist, psychiatrist, and/or other physician for the problems noted above? ☐ Yes ☐ No If yes, please provide the following information:

Date(s)	Name of Professional	Address	Treatment Type (counseling, therapy, medication, etc.)

- Please provide information regarding previous treatment your child has received from a counselor, psychologist, psychiatrist, or other medical or mental health professional for this or other problems:

Date(s)	Name of Professional	Address	Treatment Type	Why treatment ended

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COUNSELING

Has your child ever been hospitalized for treatment of an emotional or mental disorder?

☐ Yes ☐ No If yes, please provide the following information:

Date(s)	Name of Hospital or Facility	Address	Reason for Hospitalization

Medical History

- Please complete the information below regarding past and current medical conditions and treatment:

Date(s)	Physician Name / Address	Condition	Treatment	Results

Please list any allergies/sensitivities/drug reactions:

_____

_____

- Please list all current prescription and over the counter medication use:

Beginning (date)	Medication	Dose	Frequency of use	Condition Treated

Please list any previous prescription and over the counter medication use

Date(s)	Medication	Dose	Frequency of use	Condition Treated
From_____To_____				
From_____To_____				
From_____To_____				
From_____To_____				

Hope & Healing

Client Name: _____
File # _____

COUNSELING

- Please list any current or previous use of street drugs, tobacco products, or alcohol:

Date(s) Type Used Frequency of Use Amount Typically Used When ended (if applicable)

_____

_____

_____

- **Please list** any hospitalizations or surgeries:

Date(s) Hospital/Facility Physician Condition Type Treatment/Surgery

_____

_____

_____

Family of Origin

- Please list the members of your child's family of origin in the order that they were born. Include current ages. Example: Maternal grandmother (deceased), Mother (age 37), father (age 36), sister Anne (age 17), client (age 15), brother Larry (age 10)

- Please describe the background or status of your child's family of origin for the following categories:

Ethnic: Religious:

_____ _____

Social: Financial:

_____ _____

- Briefly describe any of the following that apply to your child's family of origin:
  - Crisis or other significant events:
  - Any emotional, psychological, or physical illness: (Examples: cancer, diabetes, heart disease, depression, alcoholism, drug abuse or addiction, family violence, depression, suicide)
  - Parenting styles of your child's mother, father, and other caretakers? Who does what and how?
  - Communication styles in your child's family of origin? Who does most of the talking, teaching, and connecting?

Client Name: _____
File # _____

- Your child's relationship with his/her:

  Mother:

  Father:

  Stepparent:

  Grandparents

  Siblings:

  Other significant family members:

  Friends:

  Teachers:

  Other significant persons:

Developmental History

Briefly describe your child's (1) physical, (2) psychological, (3) emotional, (4) intellectual, (5) social, (6) spiritual, and (6) academic development, and (7) any significant experiences affecting you child during the following stages of his/her life (attach extra sheets, if needed):

- Prenatal development and infancy (conception up to age 2):

- Early Childhood (age 2 through age 5):

- Middle and Late childhood (age 6 through age 11):

Parent/Guardian Signature: _____ **Date:** _____