Encourage Counseling Services

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CLIENT INFORMATION FORM
(Child Form)

To assist us in helping your child, please fill out this form as fully and openly as possible. All private information is held in strictest confidence, within legal limits. If certain questions do not apply to your child, leave them blank.

GENERAL INFORMATION **PLEASE PRINT CLEARLY**

Name of Child (First, Middle, Last)_____ Birthdate_____ Gender: M / F

Address_____ Home phone _____

City_____ State_____ Zip_____ Grade in school_____

School _____ School address _____ School phone _____

Adopted Child? ___ Yes ___ No At what age? _____ Medical/Social History of birth parents ___ Known ___ Unknown

Who has legal custody? _____

Name of person providing information _____ Relationship to Child _____

Address_____ Home phone _____

City_____ State_____ Zip_____ Cell phone _____

Occupation _____ Employer _____ Work phone _____

May we leave a message at home? ____ Y ____ N At work? ____ Y ____ N On cell? ____ Y ____ N

Person to contact in emergency (other than person listed above)_____ Phone_____

Address_____ Relationship to Child_____

Sign if you agree to disclose emergency information to the above contact _____

PRIMARY INSURANCE INFORMATION

___ self ___ parent ___ spouse ___ guardian

Insured's name _____
First Middle Last

Address (if different) _____

_____

Home phone (if different) _____

Birthdate _____

Social Security Number _____

Insured's employer _____

Work phone _____

Insurance Co. _____

Plan name _____

Insured's ID# _____

Policy Group # _____

SECONDARY INSURANCE INFORMATION

___ self ___ parent ___ spouse ___ guardian

Insured's name _____
First Middle Last

Address (if different) _____

_____

Home phone (if different) _____

Birthdate _____

Social Security Number _____

Insured's employer _____

Work phone _____

Insurance Co. _____

Plan name _____

Insured's ID# _____

Policy Group # _____

Authorization to Release Information: I authorize the release of any medical or other information necessary to process Insurance Claims.

_____
Signature **Date**

Authorization to Pay Benefits to Provider: I authorize payment of benefits directly to the therapist for the services provided. Where applicable, I also request payment of government benefits to the party who accepts assignment.

_____
Signature **Date**

COUNSELING GOALS

Briefly describe your primary concern for your child _____

_____

_____

_____

What are your *specific* counseling goals for your child? _____

_____

_____

What is your child's understanding of and attitude toward this counseling? (*please be specific*)_____

_____

_____

Has your child participated in counseling before? ___ Y ___ N If so, please note whom provided services, where, and when:

_____

How helpful was your child's previous counseling experience / what were the results? _____

_____

_____

FAMILY BACKGROUND (as it refers to your child)

Father's name_____ If deceased, age of child when he passed away _____

Age_____ Occupation_____ Education level_____ Health_____

Describe his relationship with your child, past and present _____

_____

_____

Mother's name_____ If deceased, age of child when she passed away _____

Age_____ Occupation_____ Education level_____ Health_____

Describe her relationship with your child, past and present _____

_____

_____

Marital status of the child's parents (check all that apply):

___ Parents married, together ___ Parents divorced ___ Father remarried

___ Parents not married, together ___ One parent deceased ___ Other _____

___ Parents separated ___ Mother remarried

Please indicate with whom the child resides _____

If child's parents are divorced, how old was the child when it occurred and how did he/she respond to it? _____

_____

Please list all of your child's siblings, in the order of their birth:

Name	Age	Gender	Biological/Step/Half-Sibling	Lives with your child?

Please briefly describe your child's relationship with his/her siblings _____

_____

_____

Briefly describe the style of parenting used with the child _____

_____

_____

How is love expressed in your child's home? _____

_____

How is anger expressed in your child's home?_____

_____

RELIGIOUS ORIENTATION

What is your child's family's present religious affiliation?

____ Catholic
____ Jewish
____ Protestant (specify denomination if any) _____
____ None, but I believe in God
____ Atheist or agnostic
____ Other (please specify) _____

How important is religious commitment to your child/child's family?

Unimportant Average importance Extremely important
1 2 3 4 5 6 7

Do you desire to have your child's/family's religious beliefs and values incorporated into the counseling process?

_____Yes _____No _____Not sure (If Yes, please explain): _____

PHYSICAL AND DEVELOPMENTAL HEALTH

Mother's health during pregnancy: _____ unknown _____ good _____ some difficulty _____ many difficulties

_____ Anemia	_____ Bleeding	_____ Nausea and vomiting
_____ Diseases	_____ Blood pressure	_____ Headaches
_____ Poor diet	_____ Weight problems	_____ Other _____
_____ Accidents	_____ Toxemia	_____

Medication/drugs taken during pregnancy (specify) _____
Length of labor _____ hours Forceps used? _____Yes _____ No Birth weight _____
Problems/complications during or after delivery _____
Child's health at birth _____

Please indicate the age at which your child accomplished each of the following:

_____ Sat alone	_____ Walked alone	_____ Used sentences
_____ Crawled	_____ First words	_____ Toilet trained

Please indicate if your child has a history of or current problem in any of the following areas:

_____ Eating problems	_____ Headaches	_____ Bed wetting
_____ Sleep difficulties	_____ Head injuries	_____ Wetting pants
_____ High temperatures	_____ Other serious injury	_____ Soiling pants

Child's present health status (circle one): Excellent Good Fair Poor

On average, how many hours of sleep does your child get daily? _____

List any changes in sleeping patterns in the last 6 months_____

List any changes in eating patterns in the last 6 months_____

Name, phone, and address of your child's primary care physician _____

_____

List any serious illnesses/operations/hospitalizations your child has had and when _____

_____

Please list all medications your child is currently taking, including the frequency, dosage and purpose (*including over-the-counter medications)* _____

_____

_____

List any allergies and/or adverse reactions to medications _____

Check substances your child uses <u>in any amount</u>		**How much is used per**			
	Age first used	Weekday	Weekend	Month	Last used
☐ Beer	_____	_____	_____	_____	_____
☐ Liquor	_____	_____	_____	_____	_____
☐ Wine	_____	_____	_____	_____	_____
☐ Marijuana	_____	_____	_____	_____	_____
☐ Cocaine/Crack	_____	_____	_____	_____	_____
☐ Methamphetamine/Crystal	_____	_____	_____	_____	_____
☐ Heroin	_____	_____	_____	_____	_____
☐ Barbiturates (downers)	_____	_____	_____	_____	_____
☐ PCP, LSD (Hallucinogens)	_____	_____	_____	_____	_____
☐ Tobacco (in any form)	_____	_____	_____	_____	_____
☐ Other _____	_____	_____	_____	_____	_____

Has your child ever used alcohol or drugs before or during school? ☐ yes ☐ no

Has your child ever missed school (or been truant) because of use or just to use? ☐ yes ☐ no

Has your child ever avoided non-users? ☐ yes ☐ no

How often does your child get drunk/high? _____

About how often does your child use more than one drug when he/she gets high? _____

Is there a history of problems with drug or alcohol use in your family? ☐ yes ☐ no

Has your child been seeing or hearing things that other people in the same room are not seeing or hearing? ____Yes ____No

If yes, please describe _____

_____

Has your child ever experienced any abuse or neglect? If so, please describe _____

_____

_____

Please identify any family history of:

_____ Alcoholism	_____ Mental retardation	_____ Learning difficulties
_____ Drug use	_____ Emotional problems	_____ Depression
_____ Suicide	_____ Hyperactivity	_____ Bipolar Disorder
_____ Physical or sexual abuse		_____ Other _____

Check the behaviors and symptoms that your child exhibits <u>frequently</u>:

____ loses temper easily	____ burglary	____ expelled from school
____ argues with adults	____ 'cons' other people	____ drug abuse
____ refuses adults' requests	____ runs away from home	____ alcohol consumption
____ deliberately annoys people	____ truant at school	____ depression
____ blames others for own mistakes	____ inattention to details	____ shy/avoidant/withdrawn
____ easily annoyed by others	____ difficulty concentrating	____ suicide threats/attempts
____ angry/resentful	____ does not complete tasks	____ fatigued
____ spiteful/vindictive	____ difficulty organizing tasks	____ anxious/nervous
____ defiant	____ loses things	____ excessive worrying
____ bullies/teases others	____ easily distracted	____ sleep disturbance
____ distractibility	____ forgetful in daily activities	____ nightmares
____ initiates fights	____ fidgety/squirmy	____ panic attacks
____ uses a weapon	____ difficulty remaining seated	____ mood shifts
____ physically cruel to people	____ impulsive/acts without thinking	____ homicidal threats/attempts
____ physically cruel to animals	____ hyperactivity	____ other (please specify)
____ stealing	____ difficulty awaiting turn	_____
____ forced sexual activity	____ interrupts others	_____
____ intentional arson	____ poor grades in school	_____

Please give examples of how each of the symptoms checked impacts your child's or other people's lives. Use the back of this sheet if necessary.

_____

_____

_____

EDUCATIONAL AND SOCIAL CONCERNS

Does your child enjoy school? _____ Yes _____ No
What grades does your child typically receive? _____
Have these grades changed recently? _____ Yes _____ No

List your child's three primary difficulties in school: 1) _____

2) _____

3) _____

How many friends does your child have? _____ Briefly describe your child's friendships _____

_____

What are your child's hobbies and interests? _____

_____

Has the frequency with which your child participates in these activities changed recently? _____ Yes _____ No

Thought Provoking Questions:

What do you want your child to achieve in life? _____

_____

_____

What has been the most significant loss your child has experienced? _____

_____

_____

Who is your child most connected to in his/her life? _____

_____

_____

List your child's three greatest strengths 1)_____

2) _____

3) _____

List your child's three greatest weaknesses 1)_____

2) _____

3) _____

As legal guardian/custodial parent of the child listed above, do you give permission for him/her to receive counseling/assessment from Encourage Counseling Services? _____

Signature:_____ Date:_____