**Child/Adolescent Personal Information:**

Name: First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I. \_\_\_\_\_\_ Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: [ ]  M [ ]  F

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_
 Street City State Zip code

Phone: Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work:\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_ SSN# \_\_\_\_\_ - \_\_\_\_\_ -\_\_\_\_\_\_\_ School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_

**Responsible Party:**

Name: First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I. \_\_\_\_\_\_ Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: [ ]  M [ ]  F

Phone: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_
 Street City State Zip code

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child/Adolescent:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

Will child/teen treatment be covered by: [ ]  Insurance: If so, What Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  If Multiple Insured: Primary:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EAP Program? [ ]  No [ ] Yes: EAP/Contact Person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder:**

Name: First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I. \_\_ Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: [ ]  Male [ ]  Female

Phone: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_
 Street City State Zip code

Insured date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS# of insured: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Relationship to client: [ ]  Parent [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorized Person's Signature:** I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party below:

**Signed** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insured or Authorized Person's Signature:** I authorize payment of medical benefits to the Counseling and Wellness Center for services:

**Signed** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Presenting Problem: What Concerns Led You to Seek Help for Your Child/Teen at this Time?**

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

**Medical Information & History**

Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Physical Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications & Dosage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were there any pregnancy complications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth difficulties and/or injuries? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was Your Pregnancy: [ ]  Full Term [ ]  Early Discoloration? [ ]  Yes [ ]  No

Birth Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any Pregnancy/Birth Complications: [ ]  Yes [ ]  No

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

What aches, pains or physical discomfort does this child/teen have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have there been any major medical problems in the past? (For example, serious illnesses, hospitalization, operations, prolonged treatment, limited activity, etc.).

Problem Where treated/hospitalized How long? Physician Results

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

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

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

Have you ever sought psychiatric, drug, alcohol or neurologic help for your child/teen? Is so, when and where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Have other medications been used to help with your child’s/teen’s behavior? If so, which one(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Family Information**

**Father**: Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Highest grade completed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Degree\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mother:** Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Highest grade completed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Degree\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parents**: [ ] [ ]  Married How long? \_\_\_\_\_\_ Are there problems in your marriage? [ ]  Yes [ ]  No

 [ ] [ ]  Divorced When? \_\_\_\_\_\_\_\_\_\_\_ [ ] [ ]  Separated How long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often does the child see his/her Father?\_\_\_\_\_\_\_\_\_\_\_ Mother? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*Who do ***court papers*** indicate has ***decision making authority*** in ***healthcare*** matters? **(these papers must be provided)** [ ] Father [ ]  Mother [ ]  Joint

Who all lives in the home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Siblings** Age M/F Still at home? Grade/Occupation

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ [ ]  M [ ]  F [ ]  Yes [ ]  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ [ ]  M [ ]  F [ ]  Yes [ ]  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ [ ]  M [ ]  F [ ]  Yes [ ]  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ [ ]  M [ ]  F [ ]  Yes [ ]  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your **Child/Teen** experienced any of the following:

[ ] [ ]  Traumatic Events [ ] [ ]  Deaths [ ] [ ]  Natural Disasters [ ] [ ]  Abuse [ ] [ ]  Medical Problems

[ ] [ ]  Psychiatric Problems [ ] [ ]  Prolonged Separation from Family [ ] [ ]  Other

Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has **Any Other Family member(s)** experienced any of the following:

[ ] [ ]  Traumatic Events [ ] [ ]  Deaths [ ] [ ]  Natural Disasters [ ] [ ]  Abuse [ ] [ ]  Medical Problems

[ ] [ ]  Psychiatric Problems [ ] [ ]  Prolonged Separation from Family [ ] [ ]  Other

Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Involvement w/Social Agency (e.g. Community Agency, Court, DHHR)? [ ]  Yes [ ]  No

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

Do you attend religious services? [ ]  Yes [ ]  No

How important is Faith to you? (Not Important) [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 (Very Important)

Is there anything else you’d like the Clinician/Medical Provider to know about your family situation?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Developmental History**

Early Feeding: [ ]  Bottle [ ]  Breast [ ]  Fussy Eater [ ]  Vomiting [ ]  Over Eating [ ]  Under Eating

Please Identify Early Child Development Milestones with the Following:

Talking: [ ]  Early [ ]  On Time [ ]  Late

One Word: [ ]  Early [ ]  On Time [ ]  Late

Two Words [ ]  Early [ ]  On Time [ ]  Late Sentences: [ ]  Early [ ]  On Time [ ]  Late

Crawling: [ ]  Early [ ]  On Time [ ]  Late

Walking: [ ]  Early [ ]  On Time [ ]  Late

Toilet Training: [ ]  Early [ ]  On Time [ ]  Late

Did you ever seek help from the following:

[ ]  Speech Therapist [ ]  Occupational Therapist [ ]  Physical Therapist

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychological Testing? [ ]  Yes [ ]  No When?\_\_\_\_\_\_\_\_ By whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**School Information**

Is your child/teen in: [ ]  Special Classes [ ]  IEP [ ]  504 Plan

Has your child/teen repeated any grades? [ ]  Yes [ ]  No If so, which grade(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Grades on Report Card: [ ]  A’s [ ]  B’s [ ]  C’s [ ]  D’s [ ]  F’s Last year’s GPA: \_\_\_\_\_\_\_\_

School Guidance Counselor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check any Subject presenting difficulty to your Child/Teen:

 [ ]  Reading [ ]  Spelling [ ]  Writing

 [ ] Language [ ]  Arithmetic [ ]  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Behavior**

What interests your Child/Teen?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My Child/Teen is having problems at: [ ]  School [ ]  Home [ ]  Both

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My Child/Teen has difficulty relating to: [ ]  Family [ ]  Peers [ ]  Authority [ ]  All the Above [ ]  None

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does this child/teen compare with other children developmentally?

 [ ]  Advanced [ ]  Typical [ ]  Delayed

**Please check** any words that apply to your child/teen:

**[ ]**

|  |  |  |
| --- | --- | --- |
| [ ]  Disobeys Mother | [ ]  Cries Easily | [ ]  School Refusal |
| [ ]  Disobeys Father[ ]  Shy | [ ]  Is Irritable[ ]  Lacks- Self Confidence | [ ]  Shows Immature Behavior[ ]  Trouble with Juvenile Court |
| [ ]  Sucks Thumb | [ ]  Over-Dependency | [ ]  Morbid Thoughts (Death, Blood.) |
| [ ]  Demands Attention | [ ]  Feels Unhappy | [ ]  Is Cruel to Animals or Pets |
| [ ]  Fears and Phobias | [ ]  Is Fearful | [ ]  Steals From Others |
| [ ]  Truancy[ ]  Over-Sensitive | [ ]  Is Stubborn[ ]  Does Not Show Feelings | [ ]  Suicidal Thoughts or Behavior[ ]  Gets Along Poorly w/ Siblings |
| [ ]  Soils Self | [ ]  Is Nervous and Jumpy | [ ]  Bizarre or Unusual Behavior |
| [ ]  Bedwetting  | [ ]  Is Bossy | [ ]  Has Sleeping Difficulties |
| [ ]  Temper Tantrums | [ ]  Is Destructive | [ ]  Is Messy |
| [ ]  Acts Out at Home | [ ]  Is Overactive | [ ]  Is Concerned about Neatness |
| [ ]  Acts Out at School | [ ]  Jealousy Resentment | [ ]  Cruelty |
| [ ]  Refuses to Share | [ ]  Has Guilt Feelings | [ ]  Is Easily Frustrated |
| [ ]  Nightmares | [ ]  Headaches | [ ]  Is Overly Suspicious |
| [ ]  Nail Biting | [ ]  Eating Problems | [ ]  Is Afraid to Defend Self |
| [ ]  Lies | [ ]  Sexual Problems | [ ]  Plays with Fire |
| [ ]  Sensory Problems[ ]  Need for Routine[ ]  Drug & Alcohol Use[ ]  Running Away | [ ]  Has a Curfew[ ]  Impulse Control[ ]  Cutting Self[ ]  Gender Identity Issues | [ ]  Has Chores at the House[ ]  Attention Problems[ ]  Anger Issues[ ]  Suspensions/Detentions |
|  |  |  |

**Strengths Checklist – Check any which apply to your child/teen**

[ ] [ ]  Bright [ ] [ ]  Insightful [ ] [ ]  Motivated [ ]  [ ]  Active

[ ] [ ]  Self-Controlled [ ] [ ]  Has Friends [ ] [ ]  Can Calm Self [ ]  [ ]  Mostly Healthy

[ ] [ ]  Can Ask for Help [ ]  Keeps Boundaries [ ]  [ ]  Has Moral Ethics [ ]  [ ]  Can Solve Problems

[ ] [ ]  Can Forgive [ ]  Expresses Feelings [ ]  [ ]  Earns Money [ ]  Good Listener[ ]

[ ] [ ]  Resourceful [ ] [ ]  Sense of Humor [ ]  [ ]  Compassionate [ ] [ ]  Patient

[ ]  Has Employment [ ]  Hard Worker [ ]  Willing to Learn

[ ]  Accepts Love & Care from Others [ ]  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship Rating – Please Rate Your Child’s/Teen’s Relationship with the Following**

Father: (Distant) [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 (Close)

Mother: (Distant) [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 (Close)

Friends: (Distant) [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 (Close)

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Distant) [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 (Close)

**Family History of**

**Alcoholism/Substance Abuse & Psychiatric Problems:**

 *(Indicate which, if any, family members you either suspect has had difficulties in these*

*areas or has received treatment for these problems)*

|  |  |  |
| --- | --- | --- |
| **Relationship** | **Problem** **(specify alcoholism, substance abuse or psychiatric)** | **Problem suspected or actually treated?** |
| GrandparentsMotherFatherBrother/SisterChildrenSpouse/Sig. OtherOther (who?) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Has your Child/Teen, or anyone family member, ever attempted suicide? [ ]  Yes [ ]  No

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

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

Has your Child/Teen, or anyone family member, ever attempted a homicide? [ ]  Yes [ ]  No

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

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

|  |  |  |
| --- | --- | --- |
|  | **No Current****Use** | **Current Use** |
| **Substance** **Category** | **Common Names****(circle all that apply)** | NeverUsed | UsedBut Quit | LessThan1X per mo. | 1 - 4Timesper mo. | 1 - 4Timesper wk. | 1 or More TimesPer Day |
| **Tobacco/** **Nicotine** | Cigarettes Snuff CigarsChewing Tobacco E-cigarettes | A | BDate:  | C | D | E | F |
| **Alcohol** | Beer Wine Hard Liquor | A | BDate:  | C | D | E | F |
| **Cannabis or** **Synthetic Marijuana** | Marinol Pot Hashish Grass Weed Hash Oil Reefer GanjaJoint Mary Jane Spice/K2 Kush | A | BDate:  | C | D | E | F |
| **Stimulants** | Cocaine (Coke; Snow; Crack; Rock; Blow; Nose; Toot; White);CrystalAmphetamines; Speed; Crank Uppers; Dexedrine; Ritalin; AdderallMethamphetamine; Diet Pills | A | BDate:  | C | D | E | F |
| **Depressants** | Tranquilizers; Sleepers; 'LudesBenzos (Xanax; Valium; Klonopin; Ambien, etc.) Barbiturates; Downers | A | BDate:  | C | D | E | F |
| **Inhalants** | Glue Gasoline AerosolsAmyl Nitrate Poppers Paint ThinnersRush Nitrous Whippets | A | BDate:  | C | D | E | F |
| **Narcotics** | Heroin Smack Horse Morphine Methadone Darvocet Codeine Percodan Hydrocodone TramadalOxycontin Vicodin Lortab Dilaudid Fentanyl Patch Duragesic Patch | A | BDate:  | C | D | E | F |
| **Hallucinogens** | LSD Peyote Mescaline PCP Acid Mushrooms MDMA(Molly; “X”; Ecstasy) Bath Salts Love Drug | A | BDate:  | C | D | E | F |
| **Over-the-Counter****Drugs** | Cold Pills Diet Pills Cough Syrups No Doz Sleep Aids Purple DrankMini Thins Yellow Jackets | A | BDate:  | C | D | E | F |

**Parental Impressions**

1. Do you think your child/teen has an emotional or learning problem? [ ]  Yes [ ]  No
2. Would it embarrass you if your child/teen has an emotional or learning problem? [ ]  Yes [ ]  No
3. Does your child’s/teen’s other parent agree that there are problems? [ ]  Yes [ ]  No
4. Do you feel, in any way responsible for your child’s/teen’s problems? [ ]  Yes [ ]  No
5. At this point, what solutions to your child’s/teen’s difficulties have you considered?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. What is your Child/Teen’s opinion on coming today?

[ ]  Resistant [ ]  Reluctant, but Willing [ ]  Neutral [ ]  Highly Motivated [ ]  I Don’t Know

1. As a Parent, what is your anticipated goal(s) for your child’s treatment?

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Additional Information: Please tell us any other significant or interesting facts about this child that we may not have asked about:

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