**Personal Information:**

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

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

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

Date of Birth: \_\_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party:**

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

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

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

Social Security # \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_Relationship to Child/Adolescent:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

Is child’s/teen’s condition related to:  Employment?  Auto Accident? State \_\_\_\_\_\_\_\_\_\_  Other Accident Will treatment be covered by an EAP Program?  No Yes: EAP/Contact Person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is child/adolescent under an employer's health plan? No  Yes: Employer's Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder:** (if policy holder is the “Responsible Party” listed above, check here  and skip to ***\*\****)

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

***\*\*If Child/Adolescent is covered under another Health Benefit Plan, please fill out another cover sheet and write "Secondary Insurer" on the top of the form.***

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

**General Information**

Father\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Mother\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you here? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of referrer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade\_\_\_\_\_\_ Teacher\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Counselor\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Physician **(if not the referral source named above)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What problems or difficulties is your child experiencing?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Have you sought help for this problem or any similar problem elsewhere?\_\_\_\_\_\_\_If so, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What, if any, Social Service Agency have you ever gone to (i.e. Court, Dept. of Health & Human Resources, Community Service Agency)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

1. Please list information for ALL the members of your child’s/teen’s family/families:

|  |  |
| --- | --- |
|  | *PLEASE USE THIS BOX IF YOUR CHILD LIVES IN A* ***SECOND HOME*** *AS WELL* |
| Name Age Relationship | Name Age Relationship |
| *e.g. Mary 35 Mother*  *Fred 37 Stepfather*  *Joey 3 Brother*  *James 1 Half brother* | *e.g. Jerry 40 Father*  *Sue 38 Father’s fiancée*  *Joey 3 Brother*  *Katie 5 Sue’s child* |
|  |  |

1. Have there been any serious medical problems in other members of the family? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Circle (and identify) any of the following, which have appeared in the family:

Reading Disorder Birth Defects Vision Problems Substance Abuse

Learning Problems Cerebral Palsy Neurological Problems Epilepsy

Allergies Intellectual Disability Emotional/Psychiatric Problems

Migraine Headaches Hearing Problems Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever sought Mental Health Assistance for anyone else in your family?\_\_\_\_\_\_\_\_\_If so, when and where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. *If both parents live in the same house with the child/teen*, how long have they been together? \_\_\_\_\_\_
3. *If the parents live apart*, how long have they lived apart?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often and for how long does the child/teen live with each one?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are there current relationship problems between the parents?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Has your child/teen experienced any significant traumatic events (deaths/natural disasters/abuse, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Have there been any deaths in the immediate family?\_\_\_\_\_\_ If so, when did this occur, and what was the cause of death?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Is there anything else you would like the therapist to know about your family situation?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**School History**

1. Did your child attend nursery school?\_\_\_\_\_ How many years? \_\_\_\_\_\_\_\_\_\_\_
2. Does your child/teen like school?\_\_\_\_\_\_\_Teachers?\_\_\_\_\_\_ Classmates?\_\_\_\_\_\_\_\_
3. Does your child/teen have difficulty relating to teachers and/or classmates? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. What, if any, problems does your child/teen have at school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Has your child/teen frequently been absent from school? \_\_\_\_\_\_ Why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Does your child/teen have an  IEP? 504 Plan?
3. Best subject\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Easiest subject\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Favorite subject\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Circle any subject(s) presenting difficulty to your child/teen:

Reading Spelling Writing Language Arithmetic (other)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Any grade(s) repeated?\_\_\_\_\_\_\_\_\_\_\_\_Remedial work or tutoring? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Does your child/teen enjoy: Reading\_\_\_\_\_\_\_\_\_ Being read to\_\_\_\_\_\_\_ Art\_\_\_\_\_\_\_\_ Music\_\_\_\_\_\_\_ Sports\_\_\_\_\_\_\_\_ Drama\_\_\_\_\_\_\_\_ Other (e.g.hobbies) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do you feel that your child/teen is working up to potential?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Biomedical History**

1. Were there any birth difficulties and/or injuries?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(e.g. length of pregnancy, discoloration, birth weight, lack of oxygen, general condition)

1. Age of: Walking\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Talking\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Toilet training\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Describe any aches, pains or physical discomfort this child has:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. What has s/he been hospitalized for in the past?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Has the child had any of the following? If yes, approximate date?

Hyperactivity\_\_\_\_\_\_\_\_ Seizures\_\_\_\_\_\_\_\_\_\_\_\_ Pneumonia\_\_\_\_\_\_\_\_\_\_\_\_\_

Ear Discharge\_\_\_\_\_\_\_\_ Convulsions\_\_\_\_\_\_\_\_\_ Head Injuries\_\_\_\_\_\_\_\_\_\_\_

High Fever\_\_\_\_\_\_\_\_\_\_\_ Allergies\_\_\_\_\_\_\_\_\_\_\_\_ Hearing Problems\_\_\_\_\_\_\_\_

Earache\_\_\_\_\_\_\_\_\_\_\_\_\_ Dizziness\_\_\_\_\_\_\_\_\_\_\_ Feeding Problems\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has the child had an accident or hard fall?\_\_\_\_\_\_\_\_\_\_\_\_\_\_Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What medication is s/he currently taking?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. When and where was the child’s last

Vision examination\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hearing examination\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Speech examination\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

bright  insightful  motivated   active

has self-control  has friends  can calm self   mostly healthy

can ask for help  keeps boundaries   has moral ethics   can solve problems

can forgive  can express feelings   earns money to meet some needs

resourceful  sense of humor   compassionate  patient   good listener

has employment  satisfied with employment  willing to learn new attitudes and behaviors

can accept love & care from others  other strengths:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Behavior**

1. What problems does your child/teen have at home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Does your child/teen have difficulty relating to family?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Does your child/teen have difficulty relating to his/her peer group?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. How does this child/teen compare with your other children?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Have medications been used to help with your child’s/teen’s behavior?\_\_\_\_\_\_If so, which have been used (and did they help)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Behavior Problem Checklist – Circle any which apply to your child/teen**

|  |  |  |
| --- | --- | --- |
| Shy | Lacks self-confidence | Refuses to share |
| Gets along poorly w/brothers  & sisters | Been in trouble with juvenile  authorities | Has morbid preoccupations  (death, etc.) |
| Disobeys mother | Cries easily | Nail biting |
| Disobeys father | Is irritable | Doesn’t tell the truth |
| Headaches | Takes things that are not his/hers | Sucks thumb |
| Demands attention | Feels unhappy | Fears and phobias |
| Shows immature behavior | Is fearful | Over-dependency |
| Truancy | Is stubborn | Jealousy resentment |
| Soils him/herself | Is nervous and jumpy | Cruelty |
| Bedwetting | Is bossy | Is afraid to defend him/herself |
| Temper tantrums | Is destructive | Shows unusual interest in fires |
| Misbehaves at home | Is overactive | Does not show feelings |
| Misbehaves at school | Has sleeping difficulties | Is concerned about neatness |
| Nightmares | Has guilt feelings | Over-sensitive |
| Eating problems | Has suicidal thoughts or behavior | Is messy |
| Sex problems | Has bizarre or unusual behavior | Is easily frustrated |
| Is cruel to animals or pets | Complains about going to school | Is overly suspicious |

**Parental Impressions**

1. Do you think your child/teen has an emotional or learning problem?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Would it embarrass you if your child/teen has an emotional or learning problem?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Does your child’s/teen’s other parent agree that there are problems?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Do you feel, in any way responsible for your child’s/teen’s problems?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. As the child’s/teen’s parent, what concerns you most about him/her?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. At this point, what solutions to your child’s/teen’s difficulties have you considered?\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Who originated the idea of coming to this facility?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Knowing your child/teen, do you feel your child would be helped more by (check all that apply):

|  |  |
| --- | --- |
| \_\_\_\_ Talking about his/her problems individually?  \_\_\_\_ A directed program to change specific behaviors?  \_\_\_\_ Psychological or Learning Disability Testing?  \_\_\_\_ Counseling with Teachers? | \_\_\_\_ Group therapy?  \_\_\_\_ Receiving medication?  \_\_\_\_ Counseling with Parents  \_\_\_\_ Play Therapy? |

Additional Information: Please tell us any other significant or interesting facts about this child that we may not have asked about (use back of page if necessary):