**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 INA* ***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):