

Form to be completed by parent or guardian

PARENT/GUARDIAN INFORMATION

Name: _____ Date: _____

Home Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

May we call you and leave messages at home? Yes No

May we call you and leave messages at work? Yes No

May we send mail to you at this address? Yes No

Marital Status: S M D W Date of Current Marriage/Separation: _____ Number of Marriages: _____

Child(ren)'s Name(s): _____ Date of Birth: _____ M F

_____ Date of Birth: _____ M F

_____ Date of Birth: _____ M F

Occupation: _____ Highest Level of Education: _____

Name of other custodial parent: _____ Phone: _____

Do you have consent from the other custodial parent for treatment of said child? Yes No If no, this will be required by therapist before counseling may begin.

How much contact per month does the child have with his biological mother/father? _____

Do you believe in God? Yes No What is your religious preference? _____

Are you a member of a church? Yes No If yes, what church? _____

How much influence does your religion have on your day-to-day activity? A lot A moderate amount A little None

EMERGENCY CONTACT

Name: _____ Relationship to child: _____

Home Phone: _____ Work Phone: _____

Address: _____ City, State, Zip: _____

Complete all remaining information according to the child coming for treatment.

GENERAL INFORMATION

Name: _____ Date of Birth: _____ M F

The child is currently living with: _____

School: _____ Grade: _____

Extracurricular activities/interests: _____

MEDICAL HISTORY

How would you rate your child's current physical health? Excellent Good Fair Poor

Is the child currently complaining of any physical problems (e.g. headaches, stomach aches)? Yes No

If yes, please explain: _____

Previous hospitalizations for medical reasons Date: _____ Reason: _____

Date: _____ Reason: _____

Please list any medical conditions or disabilities: _____

Please list any learning disabilities: _____

MEDICATION(S) Over-the-counter or prescription	DOSAGE

COUNSELING AND PSYCHIATRIC HISTORY

Has the child had any previous counseling? Yes No If yes, when? _____ For how long? _____

For what reason? _____ Name and location of counselor: _____

Has the child ever been diagnosed with or treated for any type of mental illness? Yes No If yes, which type? _____

Has anyone in the child's family ever been diagnosed with or treated for any type of mental illness? Yes No If yes, which type? _____

PSYCHIATRIC MEDICATION(S)	DOSAGE

REASONS FOR SEEKING HELP

What concerns about the child have brought you to counseling today? _____

Where are these concerns causing the most problems for YOU? Please check all that apply:

Home Work Marriage Other: _____

Where are these concerns causing the most problems for the CHILD? Please check all that apply:

Home School Friends Other: _____

When did the present concerns begin to be a problem for the child? _____

What concerns about the child have been identified by others? _____

Please indicate which of the following areas are currently problems the child. Check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Excessive fears or anxieties | <input type="checkbox"/> Bullying/picking fights |
| <input type="checkbox"/> Difficulty being away from specific family members | <input type="checkbox"/> Refusal to respond to authority |
| <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Getting into trouble at school/play | <input type="checkbox"/> Obsessions/compulsion with specific activities |
| <input type="checkbox"/> Temper tantrums | <input type="checkbox"/> Lack of motivation |
| <input type="checkbox"/> Difficulty falling asleep/inability to sleep at night | <input type="checkbox"/> Lack of self-confidence |
| <input type="checkbox"/> Decreased/increased appetite | <input type="checkbox"/> Difficulty making or keeping friends |
| <input type="checkbox"/> Loss of interest in usual activities | <input type="checkbox"/> Other: _____ |

What do you hope to gain from counseling? _____

How did you hear about HopeWorks Counseling? Friend Church Pastor Other: _____