Child's Name _______________________ DOB ___________ Age _____ Dx ______

First Visit Date (Parent) ____________________ (Client) ____________________

Presenting Complaint ____

____

____

____

How long has this been an issue? What makes it worse? ______________________

____

____

Previous Counseling/Mental Health Treatment: when-who-why? ______________________

____

What worked/did not work? ____

Past/Current Medical Issues; Date Physical Exam ______________________________

____

Current Medications/Dosage/Reason ______________________________________

Height _________ Weight __________ Ideal Weight __________ Exercise? _______________

Eating Habits/Routine ____

____

Sleeping Habits/Patterns, Dreams ______________________________________

____

Tobacco-Alcohol-Drug Use/History (Client/Family) ______________________________

____

____

Legal Concerns ____

Temper Habits/History ____

____

Fears/Separation Anxiety/Worries ______________________________________

____

Living Arrangement (Parents Married/Divorced, Siblings, Pets, Extended Family) _______________

____

____

____

____

Describe Relationship with Parent(s) ______________________________________

____

____

Describe Relationship w/Sibling(s) ______________________________________

____

Type of Housing/Neighborhood ____________________

Parents' Occupations ____________________

Early Memories/Development ____________________

____

Education (School, Year, Grades, Favorites, Goals, Etc.) ____________________

____

____

____

Job (Current/Career Plans) ____________________

____

Methods of Discipline/Training/Teaching ____________________

____

____

Social/Recreational Patterns/Peer Relations ____________________

____

____

Sexual Knowledge/Interest ____________________

____

TV/Music Interests ____________________

____

Hobbies/Sports/Games/Activities ____________________

____

____

Screen Time ____________________

Faith Involvement ____________________

Strengths (Client/Family) ____________________

____

Weaknesses/Obstacles ____________________

____

Turning Points ____________________

____

Self-Description ____________________

____

Goals for Treatment (Parent)

____

____

____

____

Goals for Treatment (Client)

____

____

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____

PLEASE CHECK ALL THAT APPLY & *CIRCLE* THE MAIN PROBLEM

Difficulty With:	Now	Past	Difficulty With:	Now	Past	Difficulty With:	Now	Past
Anxiety			People in General			Nausea		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/Partnership			Dizziness		
Panic			Friend(s)			Diarrhea		
Fears			Co-Worker(s)			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in the Throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Problems			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain in Joints		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Drugs			Thoughts/Actions of Hurting Self			Fidget Frequently		
Alcohol			Thoughts of Suicide			Speak Without Thinking		
Caffeine			Sleeping Too Much			Waiting Your Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Falling Asleep			Paying Attention		
Extreme Weight Gain			Waking Too Early			Easily Distracted by Noises		
Extreme Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head Injury			Chills or Hot Flashes		

Family History Of: (check all that apply)

Drug/Alcohol Problems		Physical Abuse		Depression	
Legal Trouble		Sexual Abuse		Anxiety	
Domestic Violence		Hyperactivity		Psychiatric Hospitalization	
Suicide		Learning Disabilities		“Nervous Breakdown”	

Any additional information you would like to include: ______________________________

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