

Comprehensive Counseling Services

Please provide the following information about your child (if more than one child, you will need to fill out a form for each child). This information will help us better understand the problems that your child is having. The information is confidential and will not be released to anyone without your written permission.

Child's Name _____ Birthday: _____
Today's Date: _____ Your Relationship to Child: _____

PROBLEMS THAT YOUR CHILD IS HAVING

Please use a checkmark (✓) to indicate which problems apply to your child at this time.

- | | |
|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Communication problems |
| <input type="checkbox"/> Suicidal thoughts or actions | <input type="checkbox"/> Low self-esteem |
| <input type="checkbox"/> Anxiety/Worries/Moody | <input type="checkbox"/> Physically abused when younger |
| <input type="checkbox"/> Panic attacks or intense fears | <input type="checkbox"/> Sexually abused when younger |
| <input type="checkbox"/> Anger/temper problems/mean | <input type="checkbox"/> Sexual problem |
| <input type="checkbox"/> Fights often/gets in many fights | <input type="checkbox"/> Violence in the family (actual or threatened) |
| <input type="checkbox"/> Temper outbursts/explosive | <input type="checkbox"/> Legal problems or vandalism |
| <input type="checkbox"/> Alcohol/other drug abuse (by child) | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Alcohol/ other drug abuse (in family) | <input type="checkbox"/> Family problems |
| <input type="checkbox"/> School problems | <input type="checkbox"/> Conflicts with mother (or step-mom) |
| <input type="checkbox"/> Truancy/Won't go to school | <input type="checkbox"/> Conflicts with father (or step-dad) |
| <input type="checkbox"/> Kicked out/expelled from school | <input type="checkbox"/> Remarried family problems |
| <input type="checkbox"/> Learning disabilities | <input type="checkbox"/> Parents having marital problems |
| <input type="checkbox"/> Trouble paying attention | <input type="checkbox"/> Problems with brother/sister |
| <input type="checkbox"/> Not getting work done | <input type="checkbox"/> Runs away from home |
| <input type="checkbox"/> Not getting homework done | <input type="checkbox"/> Very sassy or disobedient |
| <input type="checkbox"/> Not listening to teacher | <input type="checkbox"/> Too much yelling or screaming |
| <input type="checkbox"/> Fighting at school | <input type="checkbox"/> Bedwetting/pooping pants |
| <input type="checkbox"/> Financial problems (in family) | <input type="checkbox"/> Setting fires |
| <input type="checkbox"/> Death of a loved one | <input type="checkbox"/> Too shy (or clingy/afraid to leave parents) |
| <input type="checkbox"/> Major loses/difficult changes | <input type="checkbox"/> Restless/doesn't think before acting |
| <input type="checkbox"/> Frequent stealing, lying, or cheating | <input type="checkbox"/> Problems with friends |
| <input type="checkbox"/> Diagnosed as hyperactive | |

PROBLEMS COPING

Please use a checkmark (✓) to indicate which problems apply to your child.

- | | |
|---|--|
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Gaining weight (how much _____) |
| <input type="checkbox"/> Wakes up in middle of the night | <input type="checkbox"/> Losing weight (how much _____) |
| <input type="checkbox"/> Wakes up too early | <input type="checkbox"/> Not hungry |
| <input type="checkbox"/> Sleeps too much | <input type="checkbox"/> Throws up after eating |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Feels sick to stomach |
| <input type="checkbox"/> Moody or crying more than usual | <input type="checkbox"/> Constipation or diarrhea |
| <input type="checkbox"/> Feels guilty, worthless, or hopeless | <input type="checkbox"/> Difficulties concentrating |
| <input type="checkbox"/> Fatigue/low energy | <input type="checkbox"/> Problems remembering things |
| <input type="checkbox"/> Hyper/too much energy | <input type="checkbox"/> Withdrawn from others |
| <input type="checkbox"/> Loss of interest in things | <input type="checkbox"/> Repeated actions that child can't stop |
| <input type="checkbox"/> Disturbing thoughts child can't stop | <input type="checkbox"/> Can't stop: washing hands/body, counting or checking things |
| <input type="checkbox"/> Believes people are out to get him/her | <input type="checkbox"/> Believes people are picking on him/her |
| <input type="checkbox"/> "Other" (please specify) | |

Name of Child _____

Form filled out by _____

Date _____

Relationship to child _____

Has This Child . . .

Been the victim of physical abuse? Yes. At what age? _____
By whom? _____

Been the victim of sexual abuse? Yes. At what age? _____
By whom? _____

Been the victim of emotional
and verbal abuse? Yes. At what age? _____
By whom? _____

Witnessed domestic violence? Yes. At what age? _____
By whom? _____

Been the victim of other crime? Yes. At what age? _____
What crime? _____
By whom? _____

Been in a car or other accident? Yes. At what age? _____

Experienced a medical emergency? Yes. At what age? _____
Describe _____

Been in a hurricane, tornado
or bad storm? Yes. At what age? _____

Had someone close to child die? Yes. At what age? _____
Who died? _____

Been terrified or very upset
by other event? Yes. At what age? _____
Describe event(s) _____

Developmental History Supplement

Child's name _____

Completed by _____

Pregnancy, birth and delivery:

Was this a planned pregnancy?

Did you receive regular prenatal care?

Were there any medical complications?

Did you take any medications?

Cigarettes?

Alcohol?

Other drugs?

How was the birth and delivery?

Infancy

Sleeping problems?

Eating problems?

Did she/he like being held in the first year?

Did he/she cry a lot in the first year?

When he/she cried, was he/she easy to calm down?

Did he/she seem pretty active?

Compared to other babies, was he/she difficult or hard to care for?

Developmental Milestones

When did he/she begin to crawl? _____ months

When did he/she begin to walk? _____ months

When did he/she begin to use single words? _____ months

When did he/she begin to talk in sentences? _____ months

How was the child's *temperament* or "personality" as an infant and toddler" (mood, alertness, sociability, etc.)

How is this child's *mood* most of the time now?

Where does he/she *sleep*?

How does he/she *sleep*?

How is his/her *appetite*?

Has there been any *recent change* in his/her sleep, appetite, interest in activities, or daily routine?