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National Certified Counselor

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CLIENT INFORMATION

Name: _____ Employer: _____
Home Address: _____ Address: _____
City: _____ Work Phone: (_____) _____
State: _____ Zip: _____ Employed: Full Time _____ Part Time _____
Home Phone: (_____) _____ Student: Full Time _____ Part Time _____
Cell Phone: _____
E-mail Address: _____
Date of Birth: _____ Age: _____ Male: _____ Female: _____
Social Security No.: _____ Marital Status: Single _____ Married _____
Person Financially Responsible for this Account: _____ Divorced _____ Widowed _____
Insurance Provider: _____ Group Number: _____

SPOUSE/PARENT INFORMATION

Spouse _____ Parent _____
Name: _____ Employer: _____
Home Address: _____ Employer Address: _____
City: _____ Work Phone: (_____) _____
State: _____ Zip: _____ Home Phone: (_____) _____
Date of Birth: _____ Social Security No: _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____ Relationship: _____
Home Phone: (_____) _____ Work Phone: (_____) _____
Cell Phone: (_____) _____ Physician Office Phone: (_____) _____
Referred by: _____ Permission to contact Referral: Yes _____ No _____

About Your Child's Routine

What kinds of physical exercise does your child get? _____

How much coffee, cola, tea or other caffeine does your child consume each day? _____

Is your child's eating restricted in any way? How? Why? _____

Bedtime: _____ Wake-up: _____ Average hours of sleep: _____

Does your child have any problems getting enough sleep? (Please describe completely).

What does your child do in his or her free time?

About Your Child's Health

Who is your child's pediatrician? _____ Last doctor's visit? _____

Are there any concerns shared by the doctor? _____

Starting with birth and up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions your child has had.

Describe any allergies that your child has. _____

List all medications, prescribed, over-the-counter, herbal remedies, that your child takes or has taken in the last year. Please include the dosages. _____

List all previous counselors and/or psychiatrists, dates seen, and reason for being seen. _____

Is your child in a gang? _____ Has your child used illicit drugs? _____ If so, please describe the type of drugs and the frequency, age at first use, and the amounts.

About Your Child's Symptoms

Please mark all of the items that apply to your child. Feel free to add any others at the end under "Any other characteristics."

- | | | |
|---|--|--|
| <input type="checkbox"/> Accident-prone
<input type="checkbox"/> Affectionate
<input type="checkbox"/> Aggressive
<input type="checkbox"/> Argues
<input type="checkbox"/> Assaults
<input type="checkbox"/> Bathroom language
<input type="checkbox"/> Bigoted
<input type="checkbox"/> Bossy to others
<input type="checkbox"/> Breaks rules
<input type="checkbox"/> Breaks the law
<input type="checkbox"/> Bullied by others
<input type="checkbox"/> Bullies others
<input type="checkbox"/> Cheats
<input type="checkbox"/> Clowns around
<input type="checkbox"/> Competition
<input type="checkbox"/> Complains
<input type="checkbox"/> Complains of feeling sick
<input type="checkbox"/> Compliant
<input type="checkbox"/> Concern for others
<input type="checkbox"/> Conflicts at school
<input type="checkbox"/> Conflicts at home
<input type="checkbox"/> Conflicts with friends
<input type="checkbox"/> Conflicts with police
<input type="checkbox"/> Cries easily
<input type="checkbox"/> Cruel to animals
<input type="checkbox"/> Dares others
<input type="checkbox"/> Dawdles
<input type="checkbox"/> Daydreams
<input type="checkbox"/> Defiant
<input type="checkbox"/> Dependent
<input type="checkbox"/> Destructive
<input type="checkbox"/> Developmental delay s
<input type="checkbox"/> Difficulties with parent's partner
<input type="checkbox"/> Disobedient
<input type="checkbox"/> Disrupts family activities
<input type="checkbox"/> Distractible
<input type="checkbox"/> Dropping out of school
<input type="checkbox"/> Drug or alcohol use
<input type="checkbox"/> Drug sales
<input type="checkbox"/> Eating Issues
<input type="checkbox"/> Failure in school
<input type="checkbox"/> Fantasy life
<input type="checkbox"/> Fearful
<input type="checkbox"/> Feelings are easily hurt
<input type="checkbox"/> Fidgety
<input type="checkbox"/> Fighting
<input type="checkbox"/> Finger sucking
<input type="checkbox"/> Fire setting
<input type="checkbox"/> Friendly
<input type="checkbox"/> Hair chewing
<input type="checkbox"/> Head banging
<input type="checkbox"/> Hitting
<input type="checkbox"/> Hostile
<input type="checkbox"/> Hyperactive
<input type="checkbox"/> Hypochondriac
<input type="checkbox"/> Imaginary playmates | <input type="checkbox"/> Immature
<input type="checkbox"/> Inappropriate sexual behaviors
<input type="checkbox"/> Inattentive
<input type="checkbox"/> Independent
<input type="checkbox"/> Inflicts pain on others
<input type="checkbox"/> Insults others
<input type="checkbox"/> Interrupts
<input type="checkbox"/> Intimidated by others
<input type="checkbox"/> Intimidates others
<input type="checkbox"/> Intolerant
<input type="checkbox"/> Irritability
<input type="checkbox"/> Isolates
<input type="checkbox"/> Lacks organization
<input type="checkbox"/> Lacks respect for authority
<input type="checkbox"/> Learning disability
<input type="checkbox"/> Legal difficulties
<input type="checkbox"/> Lethargic
<input type="checkbox"/> Likes to be alone
<input type="checkbox"/> Loitering
<input type="checkbox"/> Loss of friends
<input type="checkbox"/> Low frustration tolerance
<input type="checkbox"/> Lying
<input type="checkbox"/> Manipulates
<input type="checkbox"/> Masturbation
<input type="checkbox"/> Mental retardation
<input type="checkbox"/> Moody
<input type="checkbox"/> Mute, refuses to speak
<input type="checkbox"/> Nail biting
<input type="checkbox"/> Name calling
<input type="checkbox"/> Needs for high degree of supervision
<input type="checkbox"/> Negativism
<input type="checkbox"/> Nervous
<input type="checkbox"/> New school
<input type="checkbox"/> Nightmares
<input type="checkbox"/> Noisy
<input type="checkbox"/> Noncompliant
<input type="checkbox"/> Obedient
<input type="checkbox"/> Obesity
<input type="checkbox"/> Only younger playmates
<input type="checkbox"/> Oppositional
<input type="checkbox"/> Outgoing
<input type="checkbox"/> Out-of-seat behaviors
<input type="checkbox"/> Overactive
<input type="checkbox"/> Picks on others
<input type="checkbox"/> Poor concentration
<input type="checkbox"/> Pouts
<input type="checkbox"/> Prejudiced
<input type="checkbox"/> Procrastinates
<input type="checkbox"/> Provokes others
<input type="checkbox"/> Rages
<input type="checkbox"/> Recent move
<input type="checkbox"/> Refuses
<input type="checkbox"/> Relationships with friends
<input type="checkbox"/> Relationships with siblings
<input type="checkbox"/> Relationships with teachers | <input type="checkbox"/> Resists
<input type="checkbox"/> Responsible
<input type="checkbox"/> Restless
<input type="checkbox"/> Rocking or other repetitive movements
<input type="checkbox"/> Runs away
<input type="checkbox"/> Sad
<input type="checkbox"/> School avoiding
<input type="checkbox"/> Self-harming behaviors
<input type="checkbox"/> Sexual preoccupation
<input type="checkbox"/> Sexually active
<input type="checkbox"/> Shy
<input type="checkbox"/> Slow-moving
<input type="checkbox"/> Slow-responding
<input type="checkbox"/> Smart-alecky
<input type="checkbox"/> Smoking
<input type="checkbox"/> Social
<input type="checkbox"/> Speech difficulties
<input type="checkbox"/> Stealing
<input type="checkbox"/> Stubborn
<input type="checkbox"/> Suicide talk or attempt
<input type="checkbox"/> Swearing
<input type="checkbox"/> Talks back
<input type="checkbox"/> Talks out
<input type="checkbox"/> Teased
<input type="checkbox"/> Teases others
<input type="checkbox"/> Temper tantrums
<input type="checkbox"/> Threatens
<input type="checkbox"/> Thumb sucking
<input type="checkbox"/> Tics-movements or noises
<input type="checkbox"/> Timid
<input type="checkbox"/> Truancy
<input type="checkbox"/> Uncooperative
<input type="checkbox"/> Uncoordinated
<input type="checkbox"/> Under-active
<input type="checkbox"/> Unhappy
<input type="checkbox"/> Unprepared
<input type="checkbox"/> Vandalism
<input type="checkbox"/> Violent
<input type="checkbox"/> Wastes time
<input type="checkbox"/> Wetting/soiling of bed/clothes
<input type="checkbox"/> Withdraws
<input type="checkbox"/> Work problems
<input type="checkbox"/> Yells
<input type="checkbox"/> Any other characteristics:
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|---|--|--|

About Your Child's Education

Age: _____ Grade: _____ Nick Names: _____ Failure or Held Back? _____

What do school personnel tell you about your child? _____

Grade	School	Average G	City	State
<u>Pre-K</u>				
K				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

About Your Child's Family

Relatives	Name	Age/Grade	Does Child Get Along Well with this Person?	Occupation
Father				
Mother				
Sister(s)				
Brother(s)				
Step Mother				
Step Sister(s)				
Step Brother(s)				
List all people who live in the home with this child:				