Demographic Information

Name: _____ Date: _____

DOB: _____ Age: _____ Sex: Male Female

Birthplace: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Name of parent(s)/guardian(s) who have legal custody of child (All legal parent(s)/guardian(s) MUST provide written consent for services):

_____

* *Address if parent/guardian lives in another residence:*
Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number(s): _____

Is it ok to leave a voicemail?	*YES*	*NO*
Is it ok to send you something in the mail?	*YES*	*NO*

How were your introduced to us? _____
If you found us online what words did you search to find us?

_____

How Have We Come to Meet?

What are the 3 biggest concerns you have for your child right now? How long have each been going one? Put them in order of importance:

- _____
- _____
- _____

What do you think your child would say his/her biggest concern(s) is/are?

_____

_____

_____

What solutions (helpful or unhelpful) have you tried to resolve the above concerns?

_____
_____
_____

Have you or your child(ren) had therapy in the past? If so, please provide treatment providers names, dates of service, what your child was seen for, and results.

_____
_____

Change is Coming…

What are your expectations from therapy and the therapist?

_____
_____

If you had a crystal ball and were able to look into the future you will say therapy has been worth it because (list concrete changes you would like to see):

_____
_____
_____

What other things would you like to see change in your life and your family's life?

_____
_____

Do you foresee any obstacles to achieving your goals/changes?

_____
_____

How long will therapy need to last to achieve the changes/goals you want? Write down a target date:

_____

List 5 strengths about your child, give examples of each:

- _____
- _____
- _____
- _____
- _____

Medical Background

Has your child ever received psychiatric services before? YES NO

If yes, how long ago, with whom, for what, and results:

Many parents have opinions on psychiatric medications, what are yours?

Does your child have any allergies (food, environmental, medicinal, animal, etc.)

Any current or past medical issues, hospitalizations, accidents, injuries or surgeries? If yes, for what?

Is your child presently under a physician's care? If so, for what?

List medications (over the counter & prescribed), nutritional or herbal supplements, alternative treatments (acupuncture, chiropractic, etc.) your child is taking/doing and reasons:

Tell us about the pregnancy of your child (full term, preemie, any complications during pregnancy or at birth, environment and situations during pregnancy and birth).

Tell us about your child's development milestones (delayed, on time, early)

Important Questions We Must Ask

Has your child ever had suicidal ideations? YES NO
If yes, please explain:

_____
_____

Has your child ever planned to hurt himself/herself? YES NO
If yes, please explain:

_____
_____

Has your child ever attempted to hurt himself/herself? YES NO
If yes, please explain:

_____
_____

Has your child ever felt like he/she wanted to seriously hurt or harm someone else?
If yes, please explain: YES NO

_____
_____

Do you have weapons in your home or access to weapons? YES NO
If yes, who has access to them and what are the safety protocols around them?

_____
_____

Is there any history past or present of abuse or violence? YES NO
If so, please explain:

_____
_____

Is your child currently using any illegal drugs or is the reason you are seeking therapy services substance related?

_____
_____
_____
_____

Has your child ever witnessed or experienced a trauma? Does your child have reoccurring nightmares, flashbacks, or avoids anything that is uncomfortable or painful? If so, please explain:

_____

_____

Are you concerned your child may see or hear things that don't appear to be real? If so, please explain:

_____
_____
_____

Has your child even been arrested, been involved with the juvenile justice system, or is engaging in behaviors that put him/her at risk? If so, please explain?

_____
_____
_____

Do you have any concerns about your child's sexuality or sexual development?

_____
_____
_____

Education, Responsibility, Recreation and Leisure

What school does your child attend? _____

What grade is your child in? _____

How are your child's grades? _____

Has your child ever been held back or receive specialized academic services? If so, for what?

_____

What concerns if any do you have about your child's education or schooling (grades, peers, relationships with teachers, etc)?

_____
_____

What would your child say he/she likes and dislikes about school:
Likes: _____
Dislikes: _____

What responsibilities does your child have at home?

_____
_____

If your child is age 15 yr. and above what other skills do you think your child needs to be independent? How is he/she learning them? What else does he/she need to gain independence?

_____

_____

What other responsibilities or skills would you like to see your child have/achieve?

_____

_____

Does your child have his/her own cell phone? YES NO

What are the rules around your child's cell phone use? Who enforces those rules?

_____

Understanding Your Family

* *Space left for therapist to draw family tree (genorgram)*

Parent's marital status:

Married Divorced Never Married Separated Domestic Partners Widowed

If 1 or both parents are absent, if so for how long and reason for absences:

_____

_____

If parents are not together please describe the parents' relationship with one another:

_____

_____

_____

Who lives in the house with the child?

_____

_____

_____

If parents not together who lives in the other house with the child?

_____
_____
_____

Does your family have any pets? If yes, names, types and relationship to each pet:
_____
_____
_____

List 5 or more strengths of your family:
_____
_____
_____
_____
___

Is there anything that gets in the way of your family being the way you want it to be?
_____
_____
_____

Describe your child's relationship with the following:
Mother:
_____
_____

Father:
_____
_____

Siblings: Age, Name and Sex:

- Sibling 1
  _____
  _____
- Sibling 2
  _____
  _____
- Sibling 3
  _____
  _____
- Sibling 4
  _____
  _____

Girl/Boyfriend:
_____
_____

Other(s):
_____
_____

Does your family belong to any religious or spiritual groups? YES NO
If yes, what is your level of involvement?

_____
_____

Who else do you consider to be part of or supportive to your family (people or affiliations):

_____
_____

Is there any other thing that you think is important for us to know about your child?

_____
_____