Northside
FAMILY COUNSELING CENTER

_____ _____ _____
Child's Last Name Child's First Name ID No.

Please provide the following information about your child:
Nick Name: _____
Date of Birth: _____ Age: _____ Ever repeated or skipped a grade? _____
School: _____ Grade: _____ Teacher: _____ Counselor: _____
Child's Address:
_____

Insurance Information:
Insurance Carrier: _____ Insurance Number: _____Group No: _____
Person Responsible for Payment: _____
Whose name is child's insurance listed under? _____ That Person's DOB: _____

Parental Information

Marital Status of Child's parents/guardians: (Please include the timing of any death/divorce/separation or union)
_____
_____

Living Arrangement
☐ Parents ☐ One Parent ☐ Different according to time ☐ Guardian
Pertinent Details:
_____

Custodial Parent/Guardian:_____Parent/Guardian: _____
Phone Number: _____ Msg/text ok? Y N Phone Number: _____Msg/text ok? Y N
Email Address: _____ Msg ok? Y N Email Address: _____Msg ok? Y N
Address: _____ Address: _____
City: _____ State: _____ Zip Code: _____ City: _____ State: ____ Zip Code: _____

Reason for Counseling:
_____
Has child ever been under a CPS investigation? Yes ☐ No ☐ If so is the case closed? Yes ☐ No ☐
If so please explain:_____
Have the custodial parents been under a CPS investigation? Yes ☐ No ☐ If so is the case closed?
Yes ☐ No ☐
If so please explain:_____

Medications:

_____

_____

Behavioral Excesses:

What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

_____

_____

_____

_____

Behavioral Deficits:

What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

_____

_____

_____

Behavioral Assets:

What does your child do that you like? What does he /she do that other people like?

_____

_____

_____

Others Concerns:

Do you have any other concerns about your child or your family that you have not mentioned yet.

_____

_____

_____

Treatment Goals:

From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST: and how much must they change for you to be satisfied?

_____

_____

_____

_____

Please provide the following information about your child:

Family History:

The name of the child's biological parents:

Mother: _____ Father: _____

Who has legal guardianship of your child? _____

_____

Who does your child currently live with? _____

_____

Who are your child's significant others living with your child?

Names	Ages	Relationship to child	Grade/Job
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who are your child's significant others NOT living with your child?

Names	Ages	Relationship to child	Grade/Job
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please describe any past counseling that either your child or any family member has had

_____
_____
_____
_____

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? If yes, Please describe:

_____
_____
_____
_____

Education History:

What school does your child attend? _____
Address:_____
Phone: _____Teachers Name:_____ Current Grade: _____
What does your child's teacher say about him/her?

_____

Other schools attended (including Pre-school)

_____
_____

Has your child ever repeated a grade? _____ If so which one(s) _____
Has your child ever received special education services?

_____
_____

Has your child experienced any of the following problems at School?

____ fighting	____lack of friends	____drug/alcohol	____ detention
____ suspension	____learning disabilities	____poor attendance	____poor grades
____gang influence	____incomplete homework	____behavior problems	

Medical History:

What is the name of your child's medical doctor? _____
Address: _____ Phone: _____
Date of your child's last medical examination: _____
Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy?
If so, please list which ones: _____

_____

Did the child's mother have any problems during the pregnancy or at delivery? _____
If so, Please describe them: _____

_____

Has your child experienced any of the following medical problems?

____A serious accident	____Hospitalization	____Surgery
____A head injury	____High fever	____Convulsions/seizures
____Eye/ear problems	____Meningitis	____Hearing problems
____Allergies	____Loss of consciousness	____Asthma

____Other _____

Please list any current medical problems or physical handicaps:

_____
_____
_____

Please list any medications your child takes on a regular basis:

_____
_____
_____

Other History:

Has your child ever experienced any type of abuse (physical, sexual, or verbal? _____
If so please describe:

_____
_____
_____
_____

Has your child ever made statements of wanting to hurt him/her self or seriously hurt someone else? _____ Has he/she ever purposely hurt himself or another? _____
If yes to either question please describe the situation:

_____
_____
_____
_____

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? _____If yes, please explain:

_____
_____
_____

Finally, what are some of the things that are currently stressful to your child and his/her family?

_____
_____
_____

_____ _____

Counselor **Date**