FOR STAFF USE ONLY:
Client #_____
Insurance Carrier_____ Policy #_____
Copay? _____ Amount $_____
Deductible? _____Amount$ _____
# of visits allowed _____

In Courage Counseling

Client's name: _____ Date: _____

Gender: __ F __ M Date of birth: _____ Age: _____ Grade in school: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ (work): _____ Ext: _____

If you need any more space for any of the following questions please use the back of the sheet.

Primary reason(s) for seeking services:

___ Anger management ____ Anxiety ____ Coping ____ Depression

___ Eating disorder ____ Fear/phobias ____ Mental confusion ____ Sexual concerns

___ Sleeping problems ____ Addictive behaviors ____ Alcohol/drugs ____ Hyperactivity

___ Other mental health concerns (specify): _____

_____

Family History

Parents

With whom does the child live at this time? _____

Are parent's divorced or separated? _____

If Yes, who has legal custody? _____

Were the child's parents ever married? Yes ___No____

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling? Yes_____ No_____

If Yes, please describe: _____

Client's Mother

Name: _____ Age: _____ Occupation: _____ ___ FT ___ PT

Where employed: _____Work phone: _____

Mother's education: _____

Is the child currently living with mother? Yes ____No ____ Natural parent ____Step-parent ___

Adoptive parent ____Foster home ____Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the mother?

____ Yes ___ No If Yes, please explain: _____

_____

How is the child disciplined by the mother? _____

For what reasons is the child disciplined by the mother? _____

Client's Father

Name: _____ Age: _____ Occupation: _____ _____ FT _____ PT

Where employed: _____ Work phone: _____

Father's education: _____

Is the child currently living with father? Yes _____No _____ Natural parent _____Step-parent ____

Adoptive parent _____Foster home _____Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the father?

____ Yes ____ No If Yes, please explain: _____

_____

How is the child disciplined by the father? _____

For what reasons is the child disciplined by the father? _____

Client's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender	Lives		Quality of relationship with the client		
_____	____	____ F ____ M	____ home	_____ away	____ poor	____ average	_____ good
_____	____	____ F ____ M	____ home	_____ away	____ poor	____ average	_____ good
_____	____	____ F ____ M	____ home	_____ away	____ poor	____ average	_____ good
_____	____	____ F ____ M	____ home	_____ away	____ poor	____ average	_____ good

Others living in the household			Relationship (e.g., cousin, foster child)			
_____	____	____ F ____ M	_____	____ poor	__ average	__ good
_____	____	____ F ____ M	_____	____ poor	__ average	__ good
_____	____	____ F ____ M	_____	____ poor	__ average	__ good
_____	____	____ F ____ M	_____	____ poor	__ average	__ good

Comments: _____

_____

_____

Family Health History

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

___ Allergies	____ Deafness	____ Muscular Dystrophy
___ Anemia	____ Diabetes	____ Nervousness
___ Asthma	____ Glandular problems	____ Perceptual motor disorder
___ Bleeding tendency	____ Heart diseases	____ Mental Retardation
___ Blindness	____ High blood pressure	____ Seizures
___ Cancer	____ Kidney disease	____ Spinal Bifida
___ Cerebral Palsy	____ Mental illness	____ Suicide
___ Cleft lips	____ Migraines	____ Other (specify): _____
___ Cleft palate	____ Multiple sclerosis	_____

Comments re: Family Health: _____

_____

Childhood/Adolescent History

Pregnancy/Birth

Has the child's mother had any occurrences of miscarriages or stillborn births? Yes ____No____
If Yes, describe: _____
Was the pregnancy with child planned? Yes ___No ____Length of pregnancy: _____
Mother's age at child's birth: ____Father's age at child's birth: ____
Child number ___ of ____ total children.
While pregnant did the mother smoke? Yes____ No _____If Yes, what amount: _____
Did the mother use drugs of alcohol? Yes _____ No____If Yes, type/amount: _____
While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication)
_____ Yes ____ No
If Yes, describe: _____
Length of labor: _____ Induced: ____ Yes __ No Caesarean? ____ Yes __ No
Baby's birth approximate weight: _____Baby's birth approximate length: _____
Describe any physical or emotional complications with the delivery: _____
_____
Describe any complications for the mother or the baby after the birth: _____
_____
Length of hospitalization: Mother: _____ Baby: _____

Infancy/Toddlerhood Check all which apply:

___ Breast fed	____ Milk allergies	____ Vomiting	____ Diarrhea
____ Bottle fed	____ Rashes	____ Colic	____ Constipation
____ Not cuddly	____ Cried often	____ Rarely cried	____ Overactive
____ Resisted solid food	____ Trouble sleeping	____ Irritable when awakened	_____ Lethargic

Developmental History Please note the age at which the following behaviors took place:

Sat alone: _____ Dressed self: _____
Took 1st steps: _____ Tied shoelaces: _____
Spoke words: _____ Rode two-wheeled bike: _____
Spoke sentences: _____ Toilet trained: _____
Weaned: _____ Dry during day: _____
Fed self: _____ Dry during night: _____
Compared with others in the family, child's development was: _____ slow _____ average _____ fast
Age for following developments (fill in where applicable)
Began puberty: _____ Menstruation: _____
Voice change: _____ Convulsions: _____
Breast development: _____ Injuries or hospitalization: _____
Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)
_____
_____

Education

Current school: _____ School phone number: _____
Type of school: _____ Public _____ Private _____ Home schooled ___Other (specify): _____
Grade: _____ Teacher: _____ School Counselor: _____
In special education? Yes _____ No_____ If Yes, describe: _____
In gifted program? Yes _____ No_____ If Yes, describe: _____

Has child ever been held back in school? Yes ___ No___ If Yes, describe: _____
Which subjects does the child enjoy in school? _____
Which subjects does the child dislike in school? _____
What grades does the child usually receive in school? _____
Have there been any recent changes in the child's grades? Yes ___ No___
If Yes, describe: _____
Has the child been tested psychologically? Yes ___ No___ If Yes, describe: ____
_____

Check the descriptions which specifically relate to your child.

Feelings about School Work:

___ Anxious ____ Passive ____ Enthusiastic ____ Fearful
___ Eager ____ No expression ____ Bored ____ Rebellious
___ Other (describe): _____

Approach to School Work:

___ Organized ____ Industrious ____ Responsible ____ Interested
___ Self-directed ____ No initiative ____ Refuses ____ Does only what is expected
___ Sloppy ____ Disorganized ____ Cooperative ____ Doesn't complete assignments
___ Other (describe): _____

Performance in School (Parent's Opinion):

___ Satisfactory ____ Underachiever ____ Overachiever
___ Other (describe): _____

Child's Peer Relationships:

___ Spontaneous ____ Follower ____ Leader ____ Difficulty making friends
___ Makes friends easily ____ Long-time friends ____ Shares easily
___ Other (describe): _____

Who handles responsibility for your child in the following areas?

School: ____ Mother ____ Father _____ Shared Other (specify): _____
Health: ____ Mother ____ Father _____ Shared Other (specify): _____
Problem behavior: ____ Mother ____ Father _____ Shared Other (specify): _____

If the child is involved in a vocational program or works a job, please fill in the following:
What is the child's attitude toward work? _____ Poor _____ Average ___ Good ___Excellent
Current employer: _____ Position: _____ Hours per week: _____
How have the child's grades in school been affected since working? _____ Lower ____ Same _____ Higher
How many previous jobs or placements has the child had? _____
Usual length of employment: _____ Usual reason for leaving: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.)

Activity	How often now?	How often in the past?

Medical/Physical Health

___ Abortion
___ Asthma
____ Blackouts
___ Bronchitis
____ Cerebral Palsy
___ Chicken Pox
____ Congenital problems
___ Croup
____ Diabetes
____ Diphtheria
____ Dizziness
____ Ear aches
____ Ear infections
____ Eczema
___ Encephalitis
___ Fevers
____ Hayfever
____ Heart trouble
____ Hepatitis
____ Hives
____ Influenza
____ Lead poisoning
____ Measles
____ Meningitis
____ Miscarriage
____ Multiple sclerosis
____ Mumps
____ Muscular Dystrophy
____ Nose bleeds
____ Other skin rashes
____ Paralysis
____ Pleurisy
____ Pneumonia
____ Polio
____ Pregnancy
____ Rheumatic Fever
____ Scarlet Fever
____ Seizures
____ Severe colds
____ Severe head injury
____ Sexually transmitted disease
____ Thyroid disorders
____ Vision problems
____ Wearing glasses
____ Whooping cough
____ Other
_____

List any current health concerns: _____

_____

List any recent health or physical changes: _____

_____

Most recent examinations _____

Type of examination	Date of most recent visit	Results
Physical examination		
Dental examination		
Vision examination		
Hearing examination		

Current prescribed medications	Dose	Dates	Purpose	Side effects

Current over-the-counter meds	Dose	Dates	Purpose	Side effects

Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs? Yes ____No ____

If Yes, describe: _____

_____

Counseling/Prior Treatment History

Information about child/adolescent (past and present):

	Yes	No	When	Where	Reaction or overall experience
Counseling/Psychiatric Treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Hospitalizations					

Behavioral/Emotional

Please check any of the following that are typical for your child:

___ Affectionate
___ Aggressive
___ Alcohol problems
___ Angry
___ Anxiety
___ Attachment to dolls
___ Avoids adults
___ Bedwetting
___ Blinking, jerking
___ Bizarre behavior
___ Bullies, threatens
___ Careless, reckless
___ Chest pains
___ Clumsy
___ Confident
___ Cooperative
___ Cyber addiction
___ Defiant
___ Depression
___ Destructive
___ Difficulty speaking
___ Dizziness
___ Drugs dependence
___ Eating disorder
___ Enthusiastic
___ Excessive masturbation
___ Expects failure
___ Fatigue
___ Frustrated easily
___ Gambling
___ Generous
___ Hallucinations
___ Head banging
___ Heart problems
___ Hopelessness
___ Hurts animals
___ Imaginary friends
___ Impulsive
___ Irritable
___ Lazy
___ Learning problems
___ Lies frequently
___ Listens to reason
___ Loner
___ Low self-esteem
___ Messy
___ Moody
___ Nightmares
___ Obedient
___ Often sick
___ Oppositional
___ Over active
___ Overweight
___ Panic attacks
___ Phobias
___ Poor appetite
___ Sad
___ Selfish
___ Separation anxiety
___ Sets fires
___ Sexual addiction
___ Sexual acting out
___ Shares
___ Sick often
___ Short attention span
___ Shy, timid
___ Sleeping problems
___ Slow moving
___ Soiling
___ Speech problems
___ Steals
___ Stomach aches
___ Suicidal threats
___ Suicidal attempts
___ Talks back
___ Teeth grinding
___ Thumb sucking
___ Tics or twitching
___ Unsafe behaviors
___ Unusual thinking
___ Weight loss
___ Withdrawn
___ Worries excessively
___ Other:

___ Fearful ____ Psychiatric problems _____

___ Frequent injuries ____ Quarrels _____

Please describe any of the above (or other) concerns: _____

_____

How are problem behaviors generally handled? _____

_____

What are the family's favorite activities? _____

_____

What does the child/adolescent do with unstructured time? _____

_____

Has the child/adolescent experienced death? (friends, family pets, other) ____ Yes _____ No

At what age? _____ If Yes, describe the child's/adolescent's reaction: _____

_____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)

____ Yes ____ No If Yes, describe: _____

_____

Any additional information that you believe would assist us in understanding your child/adolescent?

_____

_____

_____

Any additional information that would assist us in understanding current concerns or problems?

_____

_____

_____

What are your goals for the child's therapy? _____

_____

What family involvement would you like to see in the therapy? _____

_____

Do you believe the child is suicidal at this time? _____ Yes _____ No

If Yes, explain: _____

_____

For Staff Use

Therapist's comments: _____

_____

_____

_____

_____

Therapist's signature/credentials: _____ Date: _____/____/_____

Supervisor's comments: _____

_____

_____

_____

_____ Physical exam: _____ Required ___ Not required

Supervisor's signature/credentials: _____ Date: ____/_____/_____

(Certifies case assignment, level of care and need for exam)