Waterstone
child and family counseling

General Information:

Child's name: ______________________________ Nickname: ____________________

Date of Birth: __________________ Sex: Male ____ Female _____ SSN: __________________

Child lives with: ____

Parent's Name:____

Home Phone:______________________________Cell:______________________________

Address: ____

City: ______________________________ State: ____________ Zip: ____________________

Employer:__________________________ Work phone: ____________________________

Email:____

Parent's Name:____

Home Phone:______________________________Cell:______________________________

Address: ____

City: ______________________________ State: ____________ Zip: ____________________

Employer:__________________________ Work phone: ____________________________

Email:____

Who will be responsible for making/keeping appointments? ______________________________

Ok to leave phone message? Yes No Which number?___________ Ok to send mail? Yes No

Emergency contact/Relation:________________________ Phone:________________________

Child's primary care provider:____

Clinic name: ____________________________________ Phone: ________________________

Allergies Medical conditions: ____

Child's school:______________________ Teacher: ____________________ Grade: _____

Phone:____

How did you find me: ____

Is it ok if I thank this person for the referral? Yes No

Therapy Goals:

What brings you and your child in? ____

____

____

____

____

____

What have you tried that isn't working?____

____

____

____

____

What would you like to be different?____

____

____

____

Who supports you and your family in your decision to begin counseling? _______________

____

____

How will we know we are done with counseling? ____________________________________

____

____

Risk Assessment:

Has your child expressed wanting to hurt themselves or someone else?_________________

____

Are you concerned about your child wanting to hurt themselves or someone else?__________

____

Are there weapons in your home? ____

____

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Family History:

Who lives in the home? Names, ages and relationship

____ ____

____ ____

____ ____

Who are the significant adult figures in your child's life? coach, caseworker, family, sitter

____ ____

____ ____

Describe significant changes/transitions in your child's life and the age that they occurred. For example, divorce, moves, change in schools, death/loss, removal from parents' care: ___________

____

____

____

____

If parents are divorced or separated, what are the current custody and visitation arrangements?__

____

Do any family members struggle with the following challenges? (Family is defined as brother, sister, parent, grandparent, aunt, or uncle.)

Learning challenges/disability:____

Depression/Bipolar Disorder:____

Alcoholism/Drug Addiction:____

Anxiety/Panic Attacks: ____

Trauma (sexual assault, combat, abuse, etc.):____

Suicide attempts:____

Eating Disorders (anorexia/bulimia):____

Hyperactivity/ADHD:____

Psychosis:____

Other problems:____

Treatment History:

Has your child seen a therapist before? Yes No From 1-10, rate previous experiences:________

Name(s) of previous therapist(s):____

What helped?____

What didn't? ____

Has your child seen a psychiatrist in the past? Yes No Currently? Yes No

Current medications and supplements, along with dosage: _________________________________

____

Has your child been hospitalized for emotional, psychological or substance use issues? Yes No

If yes, when and for how long: ____

Location/Facility name: ____

Developmental History:

Were there any complications with the pregnancy and delivery of your child? Yes No If yes,
explain:____

____

Describe your child as a baby: ____

____

____

Have you or anyone else had concerns about your child's development? Yes No If yes,
explain: ____

____

____

Have you or anyone else had concerns about your child's social development? Yes No If yes,
explain: ____

____

____

Have you or anyone else had concerns about the intellectual or academic functioning of your
child? Yes No If yes, explain: ____

____

____

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Social and School Functioning:

Please describe how your child interacts with other children (include siblings):________________

Do you have any concerns about your child's functioning in the school environment?__________

Please describe your child's school performance:____

Has your child ever been diagnosed with a learning disability/problem?______________________

Does your child access special education services/ IEP/ 504 Plan? Yes No If yes, please explain:____

Does your child participate in any extra curricular activities?_______________________________

Cultural and Spiritual History:

What should I know about your family to best work with you? _____________________________

How important is spirituality or religion? Low Med High ________________________________

Does your child or family currently engage in spiritual activities? Yes No If yes, please explain:

Behavior Management:

Describe discipline in your home: ____

____

____

____

____

What are your expectations of your child?____

____

____

____

____

What areas does your child excel in?____

____

____

____

____

What do you enjoy about parenting? ____

____

____

____

____

Thank you for taking the time to fill out these forms completely. This information helps me to learn more about your child and your family so that we may work together more effectively.