Help us Get to Know your Child!

In order to help us get to know your child, please complete this form as completely and honestly as possible. Thank you!

Child's Legal Name_____

Nickname_____

Date of Birth_____ **School**_____ **Grade**_____

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:

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:

Behavioral Assets:
What does your child do that you like? What does he /she do that others like?

Others Concerns:
What other concerns do you have about your child or your family?

Child's Name: **Nickname:** **Birthdate:**

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?

Family Relationships:

Name of PARENT	Biological parent	Legal parent or guardian	Has custody	Nights per week	Days per week
	Yes No	Yes No	Full Shares No		
	Yes No	Yes No	Full Shares No		
	Yes No	Yes No	Full Shares No		
	Yes No	Yes No	Full Shares No		

Siblings – Name	Age	Biological Relatedness	Lives with child?	Explanation

Significant Others NOT living with your child?				
Name	Age	Relationship	Grade/Job	Role in child's life

Describe any past counseling that either your child or any family member experienced. Use the back of this page if necessary and check here _____ if you do.

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

Child's Name: **Nickname:** **Date of Birth:**

Education History:

What school does your child attend?
Address:

Phone: Teacher's Name: Current Grade:

What does your child's teacher say about him/her?

List 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 or been given an IEP/504 Plan?

Has your child experienced any of the following problems at School? (Circle all that apply)

fighting	lack of friends	drug/alcohol use	detention
suspension	learning disabilities	poor attendance	poor grades
gang influence	incomplete homework	behavior problems	

Medical History:

What is the name of your child's physician?
Address: Phone:

Date of 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:

Child's Name: **Nickname:** **Birthdate:**

Has your child experienced any of the following medical problems? (Circle all that apply)

A serious accident	Hospitalization	Surgery
A head injury	Self injury/Cutting	Convulsions/seizures
Eye/ear problems	Meningitis	Hearing problems
Allergies	Loss of consciousness	Asthma
Eating disorders	IBS/Crohn's Disease	Other _____

Please list current medical problems or physical handicaps:

Please list medications that your child takes. If your child is under the care of a psychiatrist, please complete the Release of Confidential Information so that we might be able to coordinate care with your child's psychiatriast.

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 about wanting to hurt him/herself 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:

What is currently stressful to / for your child and his/her family?