

Child's Name: _____ DOB: _____ Date: _____

Social Security No.: _____ Gender _____ Age _____

School _____ Grade: _____ Full or Part-time _____

Custodial Parents: Married _____ Separated _____ Divorced _____ Other _____

Father's Name _____

Mother's Name _____

Address: _____

Address: _____

City: _____ State: _____ Zip: _____

City: _____ State _____ Zip: _____

Home Phone: _____ Work _____

Home Phone: _____ Work _____

Cell Phone: _____

Cell Phone: _____

Email Address: _____

Email Address: _____

Employer: _____

Employer: _____

Emergency Contact: _____ Phone: _____

Referred By: _____

I will be paying by: Cash Check Credit card

Person Responsible for Bill: _____ Address (if different from above) _____

Primary Insurance: _____

Client Relation to Policy Holder: _____

Policy Holder's Name: _____ SSN: _____ DOB: _____

Policy Holder's Address: _____ City/State: _____ Zip: _____

Insurance ID No.: _____ Group: _____

Insurance Address: _____

Insurance Telephone Number: _____

May We Call You?

At times, LifeCare Counseling and Coaching staff may need to contact you regarding scheduling or other issues. If you would like to be contacted for such reasons, please indicate the telephone numbers that can be used to reach you in the space provided below.

Phone 1: _____

Phone 2: _____

May we leave a brief confidential message? Yes _____ No _____

If yes, indicate where (e.g. voice mail, answering machine) _____

May we e-mail you? Yes _____ No _____ Email address _____

Child's name: _____ DOB: _____ Age: _____

School: _____ Phone: _____

Teacher: _____ Grade: _____

How does your child do in school academically?

How does your child do in school behaviorally?

Does your child have a learning or physical disability? _____ Y, _____ N, _____ Maybe

Specify:

Does your family have specific spiritual beliefs?

Medical History

During pregnancy, did mother use: __ Cigarettes, __ Alcohol, __ Drugs, __ Experience extreme stress?

Specify frequency, amounts, and duration:

List any birth complications (Ex: Premature, jaundice, C-section, etc.)

List any medical conditions or history (Ex: surgeries, broken bones, allergies, etc.)

Does child use: __ Cigarettes, __ Alcohol, __ Drugs

Specify amount and frequency:

Primary care physician: _____ Phone: _____

Last seen on: _____

Current medications: Name Dosage Frequency

Medical allergies:

Other allergies:

In the first two years, did your child experience:

___ Separation from mother ___ Out of home care ___ Disruption in bonding

___ Depression of mother ___ Abuse ___ Neglect

___ Chronic pain ___ Chronic illness ___ Parental stress

If yes, please specify:

Reached developmental milestones: ___ On time, ___ Early, ___ Late

How many times has the child moved homes? _____

What are five adjectives that describe:

Mother: _____

Father: _____

Child: _____

Parental Relationship: _____

Family History

Biological Dad: _____ DOB: _____

Biological Mom: _____ DOB: _____

___/___/___ Married; ___/___/___ Separated; ___/___/___ Divorced

Siblings (1st to last):

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Custodial Adults (if not biological parents)

Name: _____ DOB: _____

Date became caretaker: _____

Name: _____ DOB: _____

Date became caretaker: _____

People in household, if different from above:

Does father work outside the home? ___Y, ___N: Occupation: _____

Hours: _____

Father's highest level of education: _____

Does mother work outside the home? ☐ Y, ☐ N: Occupation: _____

Hours: _____

Mother's highest level of education: _____

If separated or divorced, visitation schedule:

Has the child experienced any significant loss? ☐ If yes, explain: _____

What do you view as your child/teen's major strengths and positive traits?

What are your child/teen's hobbies?

Where do you believe your child/teen is spiritually?

Does either parent have legal issues?

List any history of mental illness or addiction in immediate or extended family (Ex: depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):

Has child witnessed domestic violence? ☐ Y, ☐ N, Specify:

How is your child disciplined? Please list each method and frequency of use:

Trauma History

Has your child been verbally abused? ☐ Y, ☐ N, ☐ Suspected. Specify

Has your child been physically abused? ☐ Y, ☐ N, ☐ Suspected. Specify:

Has your child been sexually abused? ☐ Y, ☐ N, ☐ Suspected. Specify:

Other stressors or traumas?

Check the symptoms your child displays and list the number of times per week symptom is displayed:

☐ Anger	☐ Hyperactivity	☐ Lying
☐ Anxiety	☐ Hyper vigilance	☐ Masturbates excessively
☐ Bed wetting	☐ Impaired conscience	☐ Nightmares
☐ Acts out sexually	☐ Isolation	☐ Plays out sexual themes
☐ Conduct problems	☐ Lack of empathy	☐ Obsesses
☐ Controlling day defecation	☐ Lack of motivation	☐ Over/Under eating
☐ Has unusual sexual knowledge	☐ Lethargy	☐ Phobias
☐ Day wetting	☐ Low impulse control	☐ Tantrums
☐ Depression	☐ Shy	☐ Peer problems
☐ Homicidal thoughts	☐ Plays out violent themes	☐ Running away
☐ Disassociates	☐ Low self-esteem	☐ Sleeplessness
☐ Drug or alcohol use		☐ Stealing
	☐ Somatic symptoms (headaches, stomach aches, etc.)	☐ Other: _____

How does your child handle anger?

Briefly describe your goals for your child/teen's therapy:

Please list any information you deem to be important for the therapist to know:

Reviewed by Therapist: _____

Date: _____