



Presenting Problem

What is the presenting problem, or why are you seeking therapy services?

History of presenting problem:

1. When was this first noticed? _____
2. How often does the problem occur? _____
3. How severe is the problem? _____
4. Context of problem: _____

Has your child been in counseling before? Yes No

If yes, please describe who the therapy took place with, when it occurred, and the results.

Is this client involved with outside agencies or service providers such as DCP, Department of Human Services, School Providers, or WIC? Yes No

If so, please describe which organization, with who, and the results.

Strengths of Child

- Socially Engaging
- Is Affectionate
- Shares excitement or interests with peers or adults
- Other:
- Curious/Interested
- Seems Bright

Strengths of Family/ Caregiver(s)

- Realistic expectations for child
- Family warmth
- Adequate financial resources
- Other (please specify):
- Motivated to help child
- Support within family unit
- Able to advocate for child
- Able to tune-in to child
- Effective communication
- Involved in community

Additional Demographic Information

Ethnicity (ie Italian, Irish, etc): _____

Do you actively practice a religion? Yes No

If yes, which religion? _____



List of Child's Behaviors						
Please read the following list and rate your child on each behavior. Indicate how often your child displays that behavior by circling the number which best describes the frequency of each behavior.						
Please use the following scale		1	2	3	4	5
		Never	Rarely	Occasionally	Frequently	Very Frequently
Group A			Group D			
1 2 3 4 5	Has trouble sleeping	1 2 3 4 5	Refuses to follow rules or do chores			
1 2 3 4 5	Has poor appetite		Loses Temper			
1 2 3 4 5	Seems sad or unhappy	1 2 3 4 5	Argues with parents or teachers			
1 2 3 4 5	Talks about feeling stupid or worthless	1 2 3 4 5	Blames others for their mistakes			
1 2 3 4 5	Loses interest in having fun	1 2 3 4 5	Swears			
1 2 3 4 5	Seems irritable	1 2 3 4 5	Deliberately does things to annoy other people			
1 2 3 4 5	Moody	1 2 3 4 5	Is angry or resentful			
1 2 3 4 5	Plays alone	1 2 3 4 5	Displays a tendency to carry a grudge			
1 2 3 4 5	Cries easily	1 2 3 4 5	Touchy, easily annoyed by others			
1 2 3 4 5	Seems tired	Group E				
Group B			1 2 3 4 5	Steals		
1 2 3 4 5	Complains of headaches or stomachaches	1 2 3 4 5	Runs away overnight			
1 2 3 4 5	Worries	1 2 3 4 5	Lies			
1 2 3 4 5	Lacks confidence in their abilities	1 2 3 4 5	Cuts school			
1 2 3 4 5	Needs lots of reassurance	1 2 3 4 5	Is cruel to animals			
1 2 3 4 5	Needs to be perfect	1 2 3 4 5	Destroys property			
1 2 3 4 5	Seems fearful and anxious	1 2 3 4 5	Gets into fights			
1 2 3 4 5	Seems shy or timid	1 2 3 4 5	Has been physically cruel to other people			
1 2 3 4 5	Easily embarrassed	1 2 3 4 5	Doesn't seem sorry for hurting others			
1 2 3 4 5	Sensitive to criticism	1 2 3 4 5	Sets fires			
1 2 3 4 5	Bites fingernails	1 2 3 4 5	Has broken into someone else's home/ car			
Group C						
1 2 3 4 5	Always on the go					
1 2 3 4 5	Can't sit still					
1 2 3 4 5	Doesn't seem to listen					
1 2 3 4 5	Often fails to finish things					
1 2 3 4 5	Has poor concentration with schoolwork					
1 2 3 4 5	Often fidgets or squirms in seat					
1 2 3 4 5	Easily distracted					
1 2 3 4 5	Has a hard time playing quietly					
1 2 3 4 5	Talks excessively					
1 2 3 4 5	Often interrupts or others' games					
1 2 3 4 5	Seems disorganized; often loses things					
1 2 3 4 5	Takes risks without considering danger					
1 2 3 4 5	blurts out answers to questions before they have been completed					



Substance Abuse History (if Applicable) Please check here if Not Applicable

Does the child use nicotine (vapes, Juul, tobacco) in any form? Current Suspected Past No

Does the child use alcohol? Current Suspected Past No

Does the child use caffeine (any form, including cola drinks)? Current Suspected Past No

Does the child use recreational drugs? * Current Suspected Past No

* If any answer except no, please explain type, pattern of use, and any consequences of use (ie court):

Medical History

Has the child seen a doctor within the past year? Yes No

If so, what was the reason for the visit? _____

Name of child's medical provider: _____

Is the child taking any medications, prescriptions, or over-the-counter medications? Yes No

If yes, please list below:

Medication	Dosage	Reason

Please list any major medical problems that the child has had (chronic illness, serious illnesses, operations, injuries, or trauma to the head).

Does your child have any allergies? Yes No

If yes, please list below.

Developmental History

Were there any problems with the pregnancy or delivery of the child? Yes No

Any problems with eating, sleeping, or crying spells (colic, nightmares, etc)? Yes No

Did the child demonstrate any difficulties or delays in walking, talking, or toilet training? Yes No

Have there been any family crises such as marital separation or divorce? Yes No

Have there been any mental health problems in the family of origin? Yes No

Have there been any substance use or abuse issues in the family? Yes No

Briefly describe the child's relationship to both parents: _____

Briefly describe the child's relationship with siblings: _____

Briefly describe the child's temperament: _____



School History

When did the child start school? _____

Were there any problems when the child started school? Yes No

Current School: _____ Grade Level: _____

Please provide a brief description of your child's past school performance: _____

Please provide a brief description of your child's present school performance: _____

What problems have come up during the school years? _____

How does your child get along with his/her teachers? _____

How does your child get along with his/her friends or peers in school? _____

What are your child's favorite subjects or school activities? _____

What subjects or activities does your child have problems with? _____

Family History

Has the child ever been homeless? Yes No

Is there any family history of mental illness? Yes No

Have any family members ever been affected by substance use or abuse issues? Yes No

Has the child been away from parent for an extended period? Yes No

Has there been family stress or conflict? Yes No

Has the family used community resources? Yes No

If yes, please describe briefly in the space provided.

Has the child experienced trauma (e.g. multiple or repeated events that threaten the child's sense of safety: physical/sexual abuse, witness to domestic violence, severe physical neglect; or single but significant traumatic event such as: fire, death of caregiver/significant person, dog attack, car accident, shooting)?

Yes No

If yes, please list the event that occurred, child's age at the time of the event, and the child's response to the event.

Please list everyone who lives at the child's residence, including name, age, and relationship to the child.

Please list family members living outside the home, including name, age, and relationship to the child.