Hope Springs Counseling Center, LLC
127 ½ North Broad Street, Suite 3, Monroe, GA 30655
(404)784-6809

Child/Adolescent's Name: ______________ Your Name: ______________ Date: ________

Your Name: ______________ What is your relationship to child? ______________

☐ Yes ☐ No Are you the child's legal gaurdian? If no, who is child's legal guardian? ______________

Legal guardian's address: Street Address ______________ City ________ State ______ Zip Code ______

Home phone for gaurdian: ______________ Work Phone: ______________

Social Security number for child's legal gaurdian: ______________

Who referred the child for evaluation? ______________

Why was the child referred? ______________

PRESENTING PROBLEMS AND CONCERNS

Please describe the problem that brought you here today: ______________

Please check all your child's behaviors and symptoms that you consider problematic:

☐ Distractibility
☐ Hyperactivity
☐ Impulisivity
☐ Boredom
☐ Poor memory/confusion
☐ Seasonal mood changes
☐ Sadness/depression
☐ Loss of pleasure/interest
☐ Hopelessness
☐ Thoughts of death
☐ Self-harm behaviors
☐ Crying spells
☐ Loneliness
☐ Low self-worth
☐ Guilt/shame
☐ Fatigue
☐ Fire setting
☐ Peer/sibling conflict
☐ Stealing
☐ Other ______________

☐ Change in Appetite
☐ Lack of Motivation
☐ Withdrawal from people
☐ Anxiety/worry
☐ Panic attacks
☐ Fear away from home
☐ Social discomfort
☐ Obsessive thoughts
☐ Compulsive behavior
☐ Aggression/fights
☐ Frequent Arguments
☐ Irritability/anger
☐ Homicidal thoughts
☐ Flashbacks
☐ Hearing voices
☐ Visual hallucinations
☐ Toileting problems
☐ Lying
☐ Destroys property
☐ Swearing

☐ Suspicion/paranoia
☐ Racing thoughts
☐ Excessive energy
☐ Wide mood swings
☐ Sleep problems
☐ Nightmares
☐ Eating problems
☐ Gambling problems
☐ Computer addiction
☐ Problems with pornography
☐ Loss of pleasure/interest
☐ Sexual behavior
☐ Relationship problems
☐ Work/school problems
☐ Alcohol/drug use
☐ Recurring, disturbing memories
☐ No/few friends
☐ Curfew violations
☐ Running away

Are your child's problems affecting any of the following?

☐ Handling everyday tasks ☐ Self esteem ☐ Relationships ☐ Hygiene
☐ Work/School ☐ Housing ☐ Legal matters ☐ Finances
☐ Recreational activities ☐ Health

☐ Yes ☐ No Has your child ever had thoughts, made statements, or attempted to hurt themselves?
If yes, please describe: ______

☐ Yes ☐ No Has your child had thoughts, made statements, or attempted to hurt someone else?
If yes, please describe: ______

☐ Yes ☐ No Has your child recently been physically hurt or threatened by someone else?
If yes, please describe: ______

FAMILY HISTORY

Name of child's mother: ______ Name of child's father: ______
Stepmother(s): ______
Stepfather(s): ______

City and state where child was born: ______
Who did child live with after he/she was born? ______

☐ Yes ☐ No Were the child's parents married? If divorced, list date of divorce or child's age at the time of divorce:
☐ Yes ☐ No Did they divorce? ______
☐ Yes ☐ No Did either parent remarry? If so, list date or child's age when parents remarried: ______

List all of the child's brothers and sisters including step-siblings and half-siblings:

Name of Sibling	Age	Sex (M/F)	Child's father	Child's mother

Father's job: ______ Mother's job: ______
Step-mother's job: ______ Step-father's job: ______

List all placements where child has lived (such as with parents, foster parents, group home, etc.)

Child's age at the time	Placement/Name of caretakers	Reason for leaving placement

List all of the people in the house or placement where the child currrently lives. List names and ages for any children in the placement:

List anyone the child shares a bedroom with:

DEVELOPMENTAL HISTORY

Please check if you're child has experienced any of the following types of trauma or loss:

☐ Emotional abuse
☐ Sexual abuse
☐ Physical abuse
☐ Parent substance abuse
☐ Teen pregnancy
☐ Neglect
☐ Violence in the home
☐ Crime victim
☐ Parent illness
☐ Placed a child for adoption
☐ Lived in a foster home
☐ Multiple family moves
☐ Homelessness
☐ Loss of a loved one
☐ Financial problems

☐ Yes ☐ No Were there any problems during the mother's pregnancy and/or during the child's birth or delivery?

If yes, please describe:

☐ Yes ☐ No Did the biological mother use any tobacco, medication, street drugs, or alcohol while pregnant?

If yes, please describe substances used and frequency:

☐ Yes ☐ No Did the child show any delays in walking, talking, toilet training, or in achieving any other developmental milestones?

If yes, please describe:

Does the child or child's family have a history of: (check all that apply)

☐ Child	☐ Family	Mental illness	☐ Child	☐ Family	Nelgect
☐ Child	☐ Family	Physical abuse	☐ Child	☐ Family	Unstable lyfestyle
☐ Child	☐ Family	Alcohol abuse	☐ Child	☐ Family	Emotional abuse
☐ Child	☐ Family	Dug abuse	☐ Child	☐ Family	DFCS involved
☐ Child	☐ Family	Criminal history	☐ Child	☐ Family	Frequent moving
☐ Child	☐ Family	Sexual abuse	☐ Child	☐ Family	Domestic violence
☐ Child	☐ Family	Homelessness	☐ Child	☐ Family	Psychiatric hospitalization

Please explain any items that were checked: ____________________

____

____

SCHOOL INFORMATION

What grade does the child currently attend? ____________________

☐ Yes ☐ No Has the child ever repeated a grade level? Grade(s) repeated: ____________________

☐ Yes ☐ No Does the child have any history of learning problems?

Please describe any learning problems: ____________________

☐ Yes ☐ No Does the child have any reading difficulties?

What is the child's estimated reading level (by grade)? ____________________

Indicate the type of classes and/or school the child attends:

☐ Regular classes
☐ Psychoeducational program
☐ Alternative school
☐ Home school
☐ Special education classes Specify type: ____________________
☐ Emotional/behavioral disorder classes (EBD)
☐ Other: ____________________

Check any of the problems that the child currently has in school:

☐ Problems paying attention
☐ Problems getting along with other students
☐ Problems understanding schoolwork
☐ Problems sitting still
☐ Problems following directions
☐ Being disrespectful to the teacher
☐ Other (describe): ____________________

MEDICAL INFORMATION

Date of last physical exam: ______________

Has your child experienced any of the following medical conditions during his/her lifetime?

☐ Allergies ☐ Asthma ☐ Headaches ☐ Stomach aches
☐ Chronic pain ☐ Surgery ☐ Serious accident ☐ Head injury
☐ Dizziness/fainting ☐ Meningitis ☐ Seizures ☐ Vision problems
☐ High fevers ☐ Diabetes ☐ Hearing problems ☐ Miscarriage
☐ Sleep disorder ☐ Abortion ☐ Sexually transmitted disease ☐ Other ______________

Please list any Current health concerns: ______________

Current prescription medications: ☐ None

Medication	Dosage	Date First Perscribed	Prescribed By

Current over-the-counter medications (including vitamins, herbal remedies, etc.) ______________

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your child's social support network (check all that apply):

☐ Family ☐ Neighbors ☐ Friends ☐ Students ☐ Co-workers ☐ Support/Self-Help Group
☐ Community Group ☐ Religious/Spiritual Center (which one?) ______________

To which or ethnic group does you child belong? ______________

If you child is experiencing any difficulties due to cultural or ethnic issuse, please describe: ______________

How important are spiritual matters to your child? ☐ Not at all ☐ Little ☐ Somewhat ☐ Very much

☐ Yes ☐ No Would you like spiritual/religious beliefs to be incorporated into your counseling?

Please describe your child's strengths and talents: ______________

Please describe any special area of interest or hobbies (art, books, physical fitness, etc.) ______________

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PSYCHIATRIC HISTORY

Check any of the emotional problems the child has had. List the ages when the problem began and ended. Or, put a check if the child still had the problem:

Age problem began	Age problem ended	Child still has this problem	Problem
		☐	Bedwetting
		☐	Soiling or wetting pants during the day
		☐	Nightmares
		☐	Difficulty falling asleep or staying asleep
		☐	Frequent crying
		☐	Sad much of the time
		☐	Talks about killing self
		☐	Withdraws from others
		☐	Anxiety or nervousness
		☐	Fear of seperating from caretaker
		☐	Clinging to adults
		☐	Refusal to go to school
		☐	Hyperactivity
		☐	Low Self-esteem
		☐	Difficulty paying attention
		☐	Difficulty getting along with peers
		☐	Self-harming behaviors
		☐	Complains about health (such as headaches)
		☐	Hoarding food or other things
		☐	Hearing voices
		☐	Seeing things that are not really there
		☐	Overeating
		☐	Obsession with weight
		☐	Other, please describe:

Check any of the behavioral problems the child has had. List the ages when the problem began and ended. Or, put a check if the child still had the problem:

Age problem began	Age Problem ended	Child still has this problem	Problem
		☐	Temper tantrums
		☐	Refusing to obey rules or follow adults' requests
		☐	Being disrespectful to parents
		☐	Being disrespectful to teachers
		☐	Destroying others' possessions
		☐	Damaging proberty
		☐	Setting fires
		☐	Cruelty to animals
		☐	Fighting with peers
		☐	Physical agression toward adults
		☐	Lying
		☐	Stealing
		☐	Running away
		☐	Using alcohol
		☐	Using drugs
		☐	Skipping school
		☐	Bullying or threatening others
		☐	Smearing feces
		☐	Purposely urinating or pooping outside of toilet
		☐	Other, please describe:

List any diagnoses the child has been given (such as ADHD) and list the child's age when the diagnosis was given ______________________________

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List any counseling the child has received:

Name of counselor	Reason for counseling	Ages when attended	Check if still attends counseling
			☐
			☐

List any psychiatric hospitalizations child has had:

Name of Hospital	Age at hospitalization	Length of stay	Reason for hospitalization

SUBSTANCE USE AND CRIMINAL HISTORY

Please complete the table for any substances your child has consumed:

Substance	Age First Used	Age Last Used	Typical Amount Consumed	Frequency of Use
Caffeine				
Tobacco				
Alcohol				
Marijuana				
Narcotics				
Amphetamines				
Cocaine				
Hallucinogens				
Other:				

List any criminal charges the child has had:

Name of charge	Child's age at time of charge	What was child accused of doing?	Sentence for charge

I declare that I am the custodial parent or legal guardian of this child and that I have the legal authority to bring him or her in for psychological evaluation or treatment.

Signed: ______________________ Date: ______________________