Prosper Counseling (DBA for First Street Counseling & Consulting, PLLC)

Child Client Background Information Form

Child's Name_____ Today's Date_____

Age _____ Date of Birth _____ ⑥ Male ⑥ Female

How did you find Prosper Counseling? _____

Is your home the child's primary residence? ⑥ Yes ⑥ No

Address _____City _____State _____Zip _____

E-mail _____

Primary Phone Number(s): _____

Can I leave you messages? _____

Family Composition (please list everyone who resides in the same house as the child, including any half or step brothers and sisters' names:

Name	Age / Grade	Relationship	Occupation	Does the child get along with this person?

Have you or your child ever been involved in any type of litigation? ⑥ Yes ⑥ No

If yes, please describe _____

******* If the rights of parent/guardian are determined by a court order, a copy of the most current legal custodial order is required prior to beginning services. *******

If parents are separated/divorced, contact information of parent not completing this form:

Name _____ Relationship _____

Address _____City _____State _____Zip _____

E-mail _____

Phone Number(s): _____

Is the other parent remarried? _____

Does the child have a relationship with the other biological parent? _____ If no, please explain:

_____

If yes, please complete Family Composition for other parent's household, including any half or step brothers/sisters:

Name	Age / Grade	Relationship	Occupation	Does the child get along with this person?

What is the parents style of discipline? _____

Please circle number to indicate degree of consistency and follow through (1=low/10=high): 1 2 3 4 5 6 7 8 9 10

What does your family do for fun? How often? _____

ABOUT YOUR CHILD

Current Grade_____Nick Names_____Held Back? _____

Current School _____ _____

What do school personnel tell you about your child? _____

_____

Describe your child's friendships and peer relationships at home and school: _____

_____

What are your expectations for this child? _____

_____

How is the child different from other members of the family? _____

GRADE	SCHOOL	AVERAGE GRADES	CITY	STATE
Pre-K				
K				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

ABOUT YOUR CHILD'S ROUTINE

List recent changes within the family (include travel and scheduling changes): _____

What kinds of physical exercise does your child get? _____

How much coffee, cola, tea, or other caffeine does your child consume each day? _____

Is your child's eating restricted in any way? How? Why? _____

Bedtime _____ Wake-up time _____ Hours of sleep on an average night? _____

Does your child have any problems getting enough sleep? Please describe fully. _____

_____

ABOUT YOUR CHILD'S HEALTH

Who is your child's pediatrician? _____When was the last visit? _____

Any concerns shared by the doctor? _____

Describe any allergies your child has _____

List all medications or drugs your child takes or has taken in the last year, including prescribed and over-the-counter ____

_____

_____

Starting with birth and preceding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions your child has had. _____

Is there a history of mental illness in the child's family? If so, please explain. _____

_____

Does any family member have a current or chronic illness? If so, please explain.

_____

Is your child currently in counseling elsewhere?_____

If yes, please describe? _____

Has your child ever received counseling or evaluation services? _____

If yes, please describe _____

Why are you seeking counseling? _____

What are your child's strengths? _____

What are your child's struggles? _____

How does your child handle stress? _____

What are your greatest concerns for your child? _____

How do you hope counseling to help? _____

Has your child ever attempted suicide or harmed him/herself in any way? _____

Has your child ever expressed thoughts of suicide or self-harm? _____ If yes, please provide details of when and what was said: _____

Has your child ever harmed or threatened to harm someone else? _____ If yes, please provide details of when and what occurred: _____

ABOUT YOUR CHILD'S SYMPTOMS

Please mark all of the items that apply to your child. Feel free to add any others under "Any other characteristics."

- ⑥ Accident-prone
- ⑥ Affectionate
- ⑥ Aggressive/Assaults
- ⑥ Anxious/ nervous/ timid
- ⑥ Argues/ defiant/ oppositional
- ⑥ Breaks rules/ law
- ⑥ Bullied by others
- ⑥ Bullies/ bossy of others
- ⑥ Cheats
- ⑥ Clowns around
- ⑥ Compliant
- ⑥ Complains of feeling sick
- ⑥ Conflicts at school
- ⑥ Conflicts at home
- ⑥ Conflicts with friends
- ⑥ Conflicts with authority
- ⑥ Cruel to animals
- ⑥ Dawdles
- ⑥ Dependent/ clingy
- ⑥ Depressed/ sad
- ⑥ Destructive
- ⑥ Developmentally delayed
- ⑥ Difficulty with parent(s) partner
- ⑥ Disorganized
- ⑥ Distractible/daydreams
- ⑥ Disrupts family activities
- ⑥ Drug or alcohol use
- ⑥ Eating Issues (i.e. obese)
- ⑥ Failure in school
- ⑥ Fearful/shy
- ⑥ Feelings are easily hurt
- ⑥ Fidgety
- ⑥ Fights (gets into)
- ⑥ Fire setting
- ⑥ Forgetful
- ⑥ Hair chewing
- ⑥ Head banging
- ⑥ Hitting/biting
- ⑥ Hostile
- ⑥ Hyperactive
- ⑥ Hypochondriac
- ⑥ Imaginary playmates
- ⑥ Immature
- ⑥ Inappropriate sexual behaviors/ masturbation
- ⑥ Inattentive
- ⑥ Independent
- ⑥ Inflicts pain on others
- ⑥ Insults others
- ⑥ Interrupts
- ⑥ Intimidated by others
- ⑥ Irritable
- ⑥ Isolates/ withdraws
- ⑥ Lacks concern for others
- ⑥ Lacks motivation/ procrastinates
- ⑥ Lacks respect for authority
- ⑥ Learning disability
- ⑥ Legal difficulties
- ⑥ Lethargic
- ⑥ Likes to be alone
- ⑥ Loss of friends
- ⑥ Low frustration tolerance
- ⑥ Lying/ manipulates
- ⑥ Moody
- ⑥ Mute, refuses to speak
- ⑥ Nail biting
- ⑥ Needs much supervision
- ⑥ Nightmares/ terrors
- ⑥ Noisy
- ⑥ Noncompliant
- ⑥ Only younger playmates
- ⑥ Outgoing
- ⑥ Overactive
- ⑥ Overly obedient
- ⑥ Over sensitive/ cries easily
- ⑥ Picks on others/ teases
- ⑥ Pouts
- ⑥ Refuses/ resists/ slow-responding
- ⑥ Restless
- ⑥ Rocking or repetitive movements
- ⑥ Runs away
- ⑥ Self-harming behaviors
- ⑥ Sexualized behavior
- ⑥ Sexually active
- ⑥ Smokes
- ⑥ Speech difficulties
- ⑥ Stealing
- ⑥ Stubborn
- ⑥ Suicide talk or attempt
- ⑥ Swearing/ talks back
- ⑥ Temper tantrums/ rages
- ⑥ Tics-movements or noises
- ⑥ Truancy
- ⑥ Uncooperative
- ⑥ Uncoordinated
- ⑥ Under-active
- ⑥ Unhappy
- ⑥ Violent
- ⑥ Wets bed/clothes

Any other characteristics?_____

STATEMENT OF UNDERSTANDING

I swear that all of the above information is true to the best of my knowledge

_____

Parent/Guardian's Signature Date