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This form is being completed by:_____

Client Information:

Name of Child: _____

Parents Names: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____Can I contact you at this email address? Yes No

Home Phone: _____ Can messages be left at this number? Yes No

Cell Phone: _____ Can messages be left at this number? Yes No

Other Phone Number:_____ Can messages be left at this number? Yes No

Date of Birth: _____ School Currently Attending: _____

Grade: _____ Teachers Name:_____

Financial Responsibility:

Who is financially responsible for services? _____

Insurance Company: _____

Insurance Company Address: _____

Policy Holder's Name: _____

Policy Holder's Social Security # : _____ Policy Holder's Date of Birth: _____

Policy Number: _____ Group Number: _____

Policy Holder's Employer: _____ Work Phone Number: _____

Family History:

Siblings Name:	Parents of Child:	Living in the Home: (Yes/No)	School Child Attends:

Are client's parents married? Yes /No **If no, please answer the following 4 questions:**

1. Please describe custody arrangements: _____

2. Which parent has decision making authority in the following areas?

Education_____ Medical/Mental Health_____

3. Are client's parents currently in court regarding custody arrangements? Yes No

4. Is there previous or current Child and Family Investigator (CFI) involved with family? Yes No

Has the child's family had any involvement with social services? Yes No

Do you have any family history of mental illness? (Bipolar, Schizophrenia, Depression, etc.) Yes No

Do you have any family history of learning difficulties or behavior problems? Yes No

Has child experienced and physical/sexual/emotional abuse? Yes No

If you answered yes to any of the above questions, please provide additional information below:

_____

_____

_____

Educational History:

Schools Attended: (Most Recent First)	Teacher:	Any Problems Reported:

Has child ever had any of the following?

Individualized Education Plan (IEP) Yes No _____

504 Plan Yes No _____

Individual Learning Plan (ILP) Yes No _____

Other services at school? Yes No _____

Is child currently experiencing any problems at school?

_____

Medical / Mental Health History:

Pediatrician: _____ Phone Number: _____

Date of last physical: _____ Date of last hospitalization: _____

Please list any previous counseling or other relevant treatment/therapies (counseling, occupational, speech, hospitalization, etc.):

Provider's Name:	Date Began:	Date Ended:

Has child ever been given a mental health diagnosis? _____

Please list any medications (prescription or nonprescription) that child is currently taking:

Medication:	Dosage:	Date Began:	Date Ended:	Prescribing Physician:

Please circle any of the following symptoms/conditions that child is or has experienced:

Headaches	Thoughts of Self Harm	Stress	Defiance
Dizziness	Depression	Anxiety	Hyperactivity
Head Injury	Diabetes	Feeling Out of Control	Difficulty with Attention
Fatigue	Abuse	Difficulty Sleeping	Poor Boundaries
Heart Trouble	Sexual Behavior Problems	School Problems	Restricted Interest
Irritability	Anemia	Difficulties Making Friends	Difficulty Learning
See or Hear Things that are not There	Allergies	Repetitive Behaviors	Rituals
Weight Gain or Loss	Legal Problems	Difficulty with Change	

Please list/describe any other medical disease/condition that child has experienced that is not mentioned above:

_____

Other:

What are your reasons for seeking counseling services at this time?

_____

Is there anything else you would like to share that was not asked above?

_____

How were you referred to Capitol Peak Counseling or Jennifer Worcester? _____