TO BE COMPLETED BY PARENTS

Child's Name: _____ DOB:_____ Age:_____

Sibling Name:_____Age:_____Sibling Name:_____ Age:_____

Sibling Name:_____Age:_____Sibling Name:_____ Age:_____

Address: _____ City/Zip:_____

Child's Cell Phone:_____

School: _____Grade:_____GPA:_____

Email: _____

Emergency Contact Name:_____ Relationship:_____

Phone Number:_____ Email Address:_____

Address:_____ City/Zip:_____

Relationship Status : □ Married □ Divorced □ Separated □ Never Married □ Remarried

What do you consider some of your child's strengths?

_____

_____

_____

What do you consider some of your child's challenges?

_____

_____

_____

What would you like your child to accomplish in therapy?

_____

_____

_____

Is your child currently experiencing overwhelming sadness, grief or depression?

□ **No** □ **Yes**

If yes, approximately how long?_____

Is your child currently experiencing anxiety, panic attacks or have any phobias?

□ **No** □ **Yes**

If yes, when did they begin experiencing this? _____

Is your child currently experiencing any chronic pain? If so where?

□ **No** □ **Yes**

If yes, please describe_____

Is your child drinking alcohol? □ **No** □ **Yes**

If yes what type of alcohol?_____

If yes how often is your child using alcohol?

□ **Daily** □ **Weekly** □ **Monthly** □ **Infrequently**

Is your child engaged in drug use? □ **No** □ **Yes**

If yes what drugs do you suspect your child is using?_____

If yes how often is your child using drugs?

□ **Daily** □ **Weekly** □ **Monthly** □ **Infrequently**

11. What significant life changes or stressful events has your child experienced recently:

_____

_____

_____

Referred by: □ **Friend/Family** □ **Internet** □ **Website** □ **Psychiatrist/Therapist** □ **Other**