DEMOGRAPHICS & BACKGROUND

CHILD & ADOLESCENT

Counseling being requested: ☐Individual ☐ Family

Client Info	Family Info
Date of Birth (child):_____/_____/___ Name of Client (child): _____ Preferred Name of Client (child): _____ Address of Child: _____ City:_____ Zip: _____ Email: _____ **Child is (circle all that apply):** African-American, Black, African-Caucasian, African-Hispanic, American Indian, Native American, Eskimo, Asian and African-American, Asian, Pacific Islander, Asian-American, Asian-Hispanic, Hispanic origin, Latino, Iranian, Israeli, Korean, Unknown, Unwilling to identify by race, White/Indo-European **Child's Gender Identity is (circle all that apply):** Girl, Boy, Trans MTF, Trans FTM, Genderqueer, Other **Child's Preferred Gender Pronouns (circle all that apply):** She/Her, He/His, They/Them/Their, Zie/Hir, Other **Child's Sex Assigned at Birth is (circle all that apply):** Female, Male, Intersex, Other **Child's Sexual Orientation is (circle all that apply):** Asexual, Bisexual, Gay, Heterosexual, Lesbian, Queer, Questioning, Other Grade in school: _____ Name of school: _____	Name of legal parent or guardian (1): _____ Address:_____ City:_____ Zip:_____ I am: Single ☐ Married ☐ Divorced ☐ Email: _____ Home #:_____ Cell#:_____ Work #:_____ Other #:_____ Name of legal parent or guardian (2): _____ Address:_____ City:_____ Zip:_____ I am: Single ☐ Married ☐ Divorced ☐ Email: _____ Home #:_____ Cell#:_____ Work #:_____ Other #:_____ Name of step-parent or other caretaker, including foster parent (3): _____ Address:_____ City:_____ Zip:_____ I am: Single ☐ Married ☐ Divorced ☐ Email:_____ Home #:_____ Cell#:_____ Work #:_____ Other #:_____ How many people live in your household? _____ List other members of household and relationship to child:

How did you hear about MySpectrum?

Another Counseling or Mental Health Provider	☐	Internet Search	☐
Referral from relative, friend, or MySpectrum Client	☐	Psychology Today	☐
Therapist, Psychiatrist, Physician, or Hospital Staff	❑	Other	☐

EMERGENCY CONTACT INFO

Notify:_____ Phone: _____

Relationship to client: _____

HEALTH AND MEDICAL

Primary Care Physician:_____Phone:_____

Psychiatrist:_____Phone:_____

Please list any medical problems: _____

Please list any current medications (name anddosage): _____

_____

_____

_____

If you have been given a mental health diagnosis in the past, please list the diagnoses:

_____

PREVIOUS COUNSELING

Please list any previous counseling, psychiatric treatment, or residential/in-patient care child has received:

With Whom: _____

Dates:_____

Reason(s): _____

With Whom: _____

Dates:_____

Reason(s): _____

With Whom: _____

Dates:_____

Reason(s): _____

With Whom: _____

Dates:_____

Reason(s): _____

With Whom: _____

Dates:_____

Reason(s): _____

Have you, your child, or family member obtained services from MySpectrum before?

☐Yes ☐No If yes, when?

_____

ADDITIONAL INFO

In child's words, why is he/she here:

As the parent/guardian, my top reason(s) for bringing my child to therapy today are:

Are you or your child required by a court of law to receive counseling as part of a legal proceeding? ☐**Yes** ☐**No**
Please provide details:

LEGAL HISTORY (of parent or guardian)

Are you facing any current or future civil or criminal legal issues? ☐ Yes ☐No

Have you been subject to a restraining order in the last 10 years?☐ Yes☐No

Have you filed for a restraining order in the last 10 years? ☐ Yes ☐No

Have you experienced any legal issues relating to divorce or child custody in the last 10 years? ☐ Yes ☐No

Do you expect the possibility of legal issues relating to divorce or child custody in the next 5 years? ☐Yes ☐ No

TRAUMA/ABUSE HISTORY

Has your child ever experienced a severe trauma? ☐ Yes ☐ No ☐ Maybe
If yes or maybe, please explain:

Has your child ever been physically or sexually abused? ☐ Yes ☐ No ☐Maybe
If yes or maybe, please explain:

RELIGIOUS/SPIRITUAL INFORMATION

Is Faith, Religion or Spirituality important to your child? □ Yes □ No □ Maybe. If yes or maybe, please explain:

PERSONAL STRENGTHS

Please list three things that you are proud of about yourchild:
1)
2)
3)

Please list three personal strengths of your child:
1)
2)
3)

Symptom Assessment

Please give as accurate account as you can and if you have any questions or concerns, we invite you to discuss them with your Therapist.

(✓ your child's concerns)

I AM EXPERIENCING…	Never	Seldom	Often	Always	For how long?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about a trauma					
"Flashbacks" as if reliving the traumatic event					
Avoiding people/places associated with trauma					
Nightmares about traumatic experience					
I AM FEELING…	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
Decreased interest in pleasurable activities					
Social Isolation, Loneliness					
Suicidal Thoughts					
Bereavement or Feelings of Loss					
Changes in sleep (too much or not enough)					
Normal, daily tasks require more effort					
Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					
I NOTICE…	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
I am Angry, Irritable, hostile					
I feel euphoric, energized and highly optimistic					
I have racing thoughts					
I need less sleep than usual					
I am more talkative					
My moods fluctuate: go up and down					
I HAVE…	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive Thoughts					
Been hearing voices when alone					
Problems with my speech					

I HAVE...	Never	Seldom	Often	Always	For how long?
Risk Taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward other(s)					
I USE THE FOLLOWING....	**Never**	**Seldom**	**Often**	**Daily**	**For how long?**
Alcohol					
Nicotine (Cigarettes)					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					
MY EATING INVOLVES...	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
Restriction of food consumption					
Bingeing and Purging					
Binge Eating					
A lot of weight loss or gain					
I HAVE...	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
Concern about my sexual function					
Discomfort engaging in sexual activity					
Questions about my sexual orientation					
EDUCATION & SELF-CARE	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
I have problems in school					
I have problems with peers					
I am involved in extra-curricular activities					
I have friends					

PERSONAL AND FAMILY HISTORY

Has <u>your child or a close relative</u> ever been hospitalized for a psychiatric illness? ☐**Yes** ☐**No**
Does anyone in your family have a mental illness? ☐**Yes** ☐**No**
Has anyone in your family every attempted or committed suicide? ☐**Yes** ☐**No**
Does anyone in your family have a substance abuse problem? ☐**Yes** ☐**No**
Have you or your child ever been arrested? ☐**Yes** ☐**No**

If "yes" to any of the above, please briefly explain: _____
_____
_____
_____
_____

(Information is based on the child's experiences)

1) How well you are doing at school: **(✓)**

0 ☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Not Working	Cannot Function		Serious Problems		Moderate Problem		Mild Problems		No Problems

2) How well you are doing with dating relationships: **(✓)**

0 ☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
N/A	Cannot Function		Serious Problems		Moderate Problem		Mild Problems		No Problems

3) How well you are doing in your family relationships: **(✓)**

0 ☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
N/A	Cannot Function		Serious Problems		Moderate Problem		Mild Problems		No Problems

4) How well you are doing in relationships with people outside your family: **(✓)**

0 ☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
N/A	Cannot Function		Serious Problems		Moderate Problem		Mild Problems		No Problems

5) Please rate your current physical health: **(✓)**

0 ☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐
Very Poor								Excellent

6) Please rate your general happiness and well-being: **(✓)**

0 ☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐

Please sign and date this form as an acknowledgement of completion to the best of your ability:

_____

Signature

_____

Date