Child/Adolescent Background Information

SMU Center for Family Counseling

5228 Tennyson Parkway*Plano, TX 75024
972-473-3456 (phone)* 972-473-3490 (fax)
www.smu.edu/familycounseling

Welcome to the Center for Family Counseling at SMU! Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. Your intake counselor will discuss your responses with you after he/she has reviewed the form.

*Child's Name:*_____ *Date of Intake:* _____
Last First MI

*Completed by:*_____ *Relationship to Child:* _____
IF NOT LEGAL GUARDIAN, PLEASE STOP HERE-THANK YOU!

Child's Legal Guardian (Managing Conservator)*:*
(If the child is not living with both natural parents, both adoptive parents, or only living parent, the Center for Family Counseling requires a photocopy of the most recent legal document stating custody arrangements, consisting of the cover page, page specifying conservator(s), and signature page). Services will not be rendered if no copy is produced.
Please initial here to indicate that you have read and understand this paragraph. _____

Child's Gender: Male__ Female__ *Date of Birth:* ___/___/___ *Age:* ____

Child's Ethnicity:
African American___ Bi-racial___ Hispanic/Latino___
Asian___ Caucasian___ Native American___ Other _____

Child's primary language: English ___ Spanish ___ Other ___
Language spoken at home (parents' language): _____

CONTACT INFORMATION:
Cell Phone: _____ (***May call?*** Yes No ***May Leave Message?*** Yes No)
Home Phone: _____ (***May call?*** Yes No ***May Leave Message?*** Yes No)
Work Phone: _____ (***May call?*** Yes No ***May Leave Message?*** Yes No)
Best Time and Place to call:_____
Child's Address:_____
Street City State Zip
May we correspond with you via mail at the specified above address: Yes No

*In case of emergency, I authorize the Center for Family Counseling to contact:*_____
Name: Last, First Relationship Phone

Person responsible for financial arrangements with our clinic: _____
Name: Last, First

Who referred you to our Center? (Please be specific): _____

May we contact this referral source to thank them for the referral: Yes No

***Please circle items you see as struggles for your child that you'd like to work on in counseling.**

Issues Related to Abuse
Current or past physical abuse
Current or past sexual abuse
Current or past emotional abuse
Current or past neglect
History of abandonment
Suspected sexual abuse
History of family domestic violence

Academic/School Issues
Learning difficulties
Problems with peers
Problems with teachers
Failing grades
Refusing to go to school
Bullying concerns
Peer/friend problems at school

Mood-Related Concerns
Disturbing memories
Difficulty going to sleep/staying asleep
Nightmares/night terrors
Suicidal thinking or talking
Irritability
Sadness/Depression
Feelings of guilt and shame
Excessive worrying or fear

Family Relationship Concerns
Difficulty adjusting to family changes
Discipline concerns
Parent-Child relationship problems
Sibling concerns
Divorce/Separation
Religious/Spiritual concerns
Constant fighting

Rule-Breaking/Behavior Issues
Aggression toward others
Drug/Alcohol use
Truancy
Gang involvement
Running away
Stealing
Intentionally hurting animals
Fire-setting

Other Behavioral Concerns
Sexual identity concerns
Inappropriate sexual behavior
Overeating/Refusal to eat
Bedwetting or soiling
Hyperactive/Impulsivity
Inattentive
Lying
Oppositional/Defiant

Other unusual behaviors (please specify) _____

***Please place a star by the most significant issue.**

*Please briefly discuss the above behaviors you have concerns about:*_____

_____

_____

*When did you first become concerned about the main/most significant issue?*_____

*Why, at this point, have you decided to pursue counseling for the concern(s) above?*_____

_____

_____

Other treatment your child has received to address any of the concerns indicated above: None___

Group Counseling___ Individual Counseling___ Family Counseling___

Hospitalization___ Play Therapy_____

Activity Therapy_____ Other _____

GENERAL OVERVIEW

1. Have other family members received services at this clinic? Yes No (Name/Dates of service)

_____

_____

2. Is your child presently receiving counseling elsewhere? Yes No
(If yes, please know we require a written confirmation of the therapist's consent for treatment by the Center for Family Counseling.)

3. Has your child ever seen a mental health professional (e.g., psychologist, counselor, etc.)*?* Yes No
(If yes, we will need your permission in order to communicate with that individual or agency).
We reserve the right to postpone services until prior treatment providers are contacted.

a. Previous Mental Health Professional/Agency: _____
Name Address

b. Phone: _____ c. *Service Dates:* _____ (beginning - ending)

What medication(s) is your child currently taking (include both psychotropic, O-T-C, etc.)?

Medication	Dosage	Taken for what reason?
_____	_____	_____
_____	_____	_____
_____	_____	_____

I agree that the above information is accurate to the best of my ability. I also understand that if I have any questions regarding the above questions, I can ask my screening/intake counselor at any time. I also understand that completing this intake does not guarantee that counseling services will be rendered at this Center.

_____

Client/Guardian Date