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

SMU | Annette Caldwell Simmons School of Education & Human Development

***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)

d. Reason for seeking counseling services at that time:_____.

e. What resulted from the counseling services at that time (i.e., did you find the counseling helpful; did your child have a positive experience; how was it decided that the counseling should end, etc.)?
_____
_____

4. Has your child been hospitalized for mental health concerns? Yes No

a. If yes: When _____ Where_____

*b. Reason for Hospitalization:*_____
_____

5. Are you seeking services because your child is a victim of a crime? Yes No

a. Did it result in legal action? Yes No *(If yes, explain)*_____

6. Are you seeking services for possible court advocacy (custody issues, abuse testimony, etc.): Yes No

*(If Yes, explain)*_____

7. Is your child currently on probation? Yes No

8. Has your child ever been suicidal? Yes No

If yes, please explain when and what happened:
_____
_____

9. Do you have any reason to believe your child is using substances: Yes No

If yes, please discuss:
_____
_____.

EDUCATION INFORMATION

*School child attends:*_____

Current School Address & Phone: _____

Length of Time at this School: _____ *How many schools has your child attended?* _____

Grade Level (now): _____ *Has your child ever been retained?* Yes No *If yes, what grade?* _____

Current Teacher(s): 1) _____ 2) _____ 3_____

Current School Counselor: _____ *Has your child met with the school counselor?* Y N

If yes, please explain why: _____

Is your child receiving special education or other services? Yes No *(explain)*_____

_____

Has your child ever been tested/assessed through the school district? Yes No ***(if yes, please bring a copy of the results so your counselor can review.)***

School Problems (check all that apply):
Academic problems___ Discipline problems___ Social Problems___ Other ___

Child's Favorite Subject: _____ *Child's Least Favorite Subject:* _____

*What does your child complain about regarding school:*_____

Has there been a recent change(s) in grades, desire to go to school, etc.: Yes No

If yes, please describe and discuss for how long change has been apparent:
_____
_____.

*How does homework go for your child (e.g., does child stay focused; where does child do homework; does homework cause fights between you and your child…why; etc.)?*_____
_____
_____
_____.

INFORMATION ON CHILD'S MOTHER

Mother's Name: _____
Last First MI
__ *biological mother* ___*stepmother* ___*adoptive mother* *Other*_____

****If your address and phone numbers are the same as your child, mark this box and skip these sections:*** ☐

Address: _____
Street City State Zip
Home Phone: _____ *Work Phone:* _____
(May call: Yes No Leave Message: Yes No) (May call: Yes No Leave Message: Yes No)

Date of Birth: _____	*Occupation:* _____
Employer: _____	*How Long:* _____

Current living arrangements:
Family of origin____ Single____ Spouse/Partner ____ Roommate____ Other____

Marital Status (indicate all that apply and duration of each, ex. 1965-1985):
Never married____ Currently married____ Divorced____

Marital History
Number of Marriages____ Number of Divorces____

History of learning issues: Yes No
(If yes, please explain) _____

History of behavioral/conduct problems: Yes No
(If yes, please explain) _____

History of emotional/mental health-related issues: Yes No
(If yes, please explain) _____

History of Suicidal Attempts: Yes No *If yes, please describe when and what happened:*
_____
_____.

History of Inpatient Psychiatric Care: Yes No If yes, please describe when and what happened:
_____
_____.

History of addictions (i.e., alcohol/drug/substance abuse, gambling, computer, etc): Yes No
(If yes, please explain) _____

History of family violence: Yes No
(If yes, please explain) _____

History of criminal activity: Yes No
(If yes, please explain) _____

History of protective orders: Yes No
(If yes, please explain) _____

INFORMATION ON CHILD'S FATHER

Father's Name: _____
Last *First* *M.*
__ *biological father* ___*stepfather* ___*adoptive father* *other* _____

If your address and phone numbers are the same as your child, mark this box and skip these sections:
☐

Address: _____
Street *City* *State* *Zip*
Home Phone: _____ *Work Phone:* _____
(May call: Yes No Leave Message: Yes No) (May call: Yes No Leave Message: Yes No)

Date of Birth: _____ *Occupation:* _____
Employer: _____ *How long:* _____

Current living arrangements:
Family of origin____ Single____ Spouse/Partner ____ Roommate____ Other____

Marital Status (indicate all that apply and duration of each, ex. 1965-1985):
Never married____ Currently married____ Divorced____

Marital History
Number of Marriages____ Number of Divorces____

History of learning issues: Yes No
(If yes, please explain) _____

History of behavioral/conduct problems: Yes No
(If yes, please explain) _____

History of emotional/mental health-related issues: Yes No
(If yes, please explain) _____

History of Suicidal Attempts: Yes No *If yes, please describe when and what happened:*
_____
_____.

History of Inpatient Psychiatric Care: Yes No *If yes, please describe when and what happened:*
_____
_____.

History of addictions (i.e., alcohol/drug/substance abuse, gambling, computer, etc): Yes No
(If yes, please explain) _____

History of family violence: Yes No
(If yes please explain) _____

History of criminal activity: Yes No
(If yes, please explain) _____

History of protective orders: Yes No
(If yes, please explain) _____

GENERAL HOUSEHOLD INFORMATION

Child's current household(s):
Adoptive Parents ___
Father only ___
Foster Family ___
Institution___
Mother only ___
Biological Father and Stepmother ___
Biological Mother and Stepfather ___
Biological Parents ___
Relatives (specify) _____
Grandparents___

List by household your child's current family, beginning with the oldest member and include the child:
Primary Household (anyone who currently lives with child)
How long in this current living situation: _____

Name	Age	Gender	Relationship to child (include step, half, etc.)

Second Household (non-custodial or extended family - if applicable)

Name	Age	Gender	Relationship to child (include step, half, etc.)

Currently involved in a custody dispute: Yes No (If yes, explain) _____
_____

If divorced, circle the number which best describes your relationship with your ex-spouse.

Hostile Frustrating Friendly
1_____2_____3_____4_____5

When did the divorce occur: _____

How often does child see other parent?_____
Describe the visitation schedule:
_____
_____

_____(Guardian Initials) I understand I must provide the Center for Family Counseling with the most current court papers, regarding custody arrangements and agreements.

CHILD'S PHYSICAL AND MENTAL HEALTH HISTORY

Child's Primary Care Physician: _____
Name Phone
_____
Address
Date of LAST complete physical: _____
Physical Disability: Yes No (If yes, explain) _____
Chronic Illness: Yes No (If yes, explain) _____
Terminal Illness: Yes No (If yes, explain) _____
Allergy History: Yes No (If yes, explain) _____
Hospitalization History (medical issues only): Please describe:
_____
_____
_____.

Does your Primary Care Physician know you are seeking Counseling Services? Yes No

Has your child ever seen a psychiatrist? Yes No
Is child currently seeing a psychiatrist? Yes No *(If yes, list name, address and phone)*:
_____
Name Phone
_____
Address

What Diagnosis has your child received from a medical professional (or previous mental health *professional)? (For example: TICS, ADD/ADHD. Anxiety, Depression, Conduct Disorder, Bipolar*

_____
_____.

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

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

History of health/physical problems includes: (check all that apply):

Asthma___	Disability___	Nervous stomach ___
Bedwetting___	Dizziness ___	Neurological problems/exam___
Bone/joint/muscle ___	Severe Headaches ___	Severe PMS ___
Chest pain ___	Heart Palpitations___	Serious overeating/under-eating__
Chronic illness___	Hospitalization___	Shortness of breath without exertion ___
Developmental delay(s) ___	Major accident___	Sleep problems___
Chronic Diarrhea ___	Major illness___	Surgeries___ Other_____

Did you child experience early language/speech issues or delays? Yes No *(If yes, please describe?*_____
_____

Has your child ever lost consciousness for a period of time? Yes No *(If yes, explain when, for how long, and what happened?*_____
_____

Does your child ever stare off into space/appear to be zoned out? Yes No *(If yes, please explain when and for how long?*_____

How much exercise does your child get each day (and through which activity): _____
_____

*How much caffeine does your child get each day?*_____

*How would you describe your child's overall diet?*_____
_____

*How much sleep does your child get each day on average?*_____
Are your child's sleep patterns consistent? _____
*Would you describe this as restful sleep?*_____
*Any sleepwalking, sleep talking, night terror, nightmares? Please explain:*_____
_____

DEVELOPMENTAL HISTORY

1) Physical:
    a) Pregnancy, delivery, feeding, sleep pattern, weaning, neonatal illnesses:

    b) Early or significant medical illnesses or injuries (e.g., Colic, G.E.R.D., etc.):

.

c) Neuromuscular development of speech, motor milestones (sitting, standing, walking, first words, play):

2) Behavioral:
   a) Toilet training and other training - response to discipline and methods used:

   b) Reactions to beginning daycare or school:

   c) Phobias/recurring fears:

   d) Habits/repeated issues (e.g., bedwetting, hair pulling, picking, thumb-sucking, etc.):

3) Current Level of Functioning:

   a) Social Adjustment:
      __ Age-appropriate peer relationship
      __Age-appropriate social etiquette
      __Age-appropriate involvement to organized groups

   b) Bathing/Dressing/Hygiene
      __Independent
      __Verbal prompts
      __Requires assistance
      __Total assistance

   c) Toileting
      __Enuresis
      __Encopresis
      __Independent
      __Needs Assistance

   d) Feeding
      __Anorexia
      __Bulimia
      __Compulsive over-eating
      __Pica Behavior (eating inanimate objects)
      __Other
      __Normal

   e) Complex Daily Living Skills
      __Age-appropriate care of possessions
      __Age-appropriate care of other's possessions
      __Age-appropriate knowledge of the use of telephone, appliances, etc.
      __Age-appropriate knowledge and applications of health issues

f) Self Harm History:
__No self-injurious behavior
__Self-harming to body
__Suicidal thoughts/comments
__Suicidal attempts

g) Substance Abuse Concerns:
__Has tried smoking
__Smokes regularly
__Has tried alcohol once or twice
__Has tried alcohol frequently
__Has tried other drugs, such as: _____
__Has not admitted to any use, but I have reason to believe or am concerned about this

h) Sexual Acting-out
__Has given NO indication of issues or concerns in this area
__Has discussed wanting to become sexually active; explain:_____
__Has admitted to trying sexual activity; explain: _____
__Engages in sexual activity frequently; explain: _____

4) Child's Daily Life Schedule (Please give general schedule from day-to-day of how your child spends his/her time):

Monday:_____
Tuesday:_____
Wednesday:_____
Thursday:_____
Friday:_____
Saturday:_____
Sunday:_____

HISTORY OF STRESSORS RELATAED TO THE CHILD

(For each of the following items that apply, write in your child's approximate age at the time it occurred if it applies to your child):

Chronic illness of family member____ Death of significant person____ Domestic Violence____
Family member absent (explain) _____
Family member's disability/major accident/illness_____
Family member emotional problems (explain)_____
Family member suicide (explain) _____
Parent's divorced___
Child separated from parent (how long and when) _____
Death of a pet___ Difficult medical treatments___ Natural Disaster___
Sexual Assault___ Other trauma (an unusual, terrifying experience) ____
Other life altering/Changing experience _____
Other general experiences that may have impacted your child significantly:_____

HOME ATMOSPHERE

*Other significant relationships, in addition to the family discussed above:*_____
_____

Name and discuss child's relationship with pets that live in the home: ____ _____
_____

Child's chores or household expectations: _____
_____

How does your child do in meeting those expectations? _____
_____

How much does your child get to play/be with friends? _____

*How does your child do in playing/interacting with other children?*_____
_____

Can your child make friends? Yes No; *Please Explain:*_____

Can your keep friends? Yes No; *Please Explain:* _____

Your child's current use of computer and television (circle the number of hours that best describes use):

Computer (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

TV (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

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