Leeds Counseling, LLC
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General Information

Client/Child's Name: _____

Client/Child's Date of Birth: _____/_____/_____

All Caregiver(s) Name(s): _____

_____

Address: _____

_____

Preferred Telephone #: _____ Email: _____

Name of person(s) completing this form: _____

Relationship to child: _____

Dear Parent/Guardian: The information that you provide is very helpful and critical in providing an accurate understanding of your concerns. Please write on the back of the page if there isn't enough space to share all the information.

Please describe, in detail, the present concern/problem (including when the problem started, how often it occurs, what stressors may contribute to the problem) and any other changes you have recently noticed in your child. Also, include any recent changes that have occurred within your family and/or in your child's environment.

_____

_____

_____

_____

Caregiver and Family History

What is the relationship status of the parents or caregivers? _____

Is the caregiver the biological parent? No Yes
If no, please explain the relationship: _____

If there was a divorce or custody, does the divorce decree or custody agreement limit, exclude, or include the other parent's or caregiver's knowledge or involvement in the child's medical care? No Yes If yes, please describe: _____

Child's Medical History

Pediatrician/Family Doctor: _____Date Last Seen: _____

Please circle any of the following medical conditions for which your child has experienced:

Seizures	Asthma	Stomach Problems	Sleep Problems	Physical Aggression
Anxiety	Depression	Suicidal Thoughts	Self-Harm	Eating Disorder
ADHD	Chronic Pain	Chronic Headaches	Chronic Fatigue	Appetite Concerns
Cancer	Head Injury	Heart Problems	Urinating/Bowel Issues	

History of medical (non-psychiatric) hospitalization? No Yes If yes, please indicate year and reason: _____

History of psychiatric hospitalization? No Yes
If yes, please indicate year and reason: _____

Is the child under care of a psychiatrist? No Yes
If yes, please indicate provider name: _____

Is the child taking any prescription medications (psychiatric or otherwise)? No Yes
If yes, indicate Condition, Name of Medication, Dosage, and any Present Side Effects:

_____

_____

Indicate Name of Prescribing Physician: _____

Caffeine Intake per day: _____ Sugar Intake: _____

How healthy does your child eat / Picky? _____

Counseling History

Has the child been in therapy before? No Yes If yes, please describe the precipitating factors leading to seeking out care in the past. _____

_____

What could be different this time to make the counseling experience better? _____

_____

Life Experiences

Has the child ever thought about committing suicide? No Yes
If yes, please briefly describe: _____

_____

Has the child ever attempted suicide? No Yes
If yes, please briefly describe any attempts including any medical care received:

_____

Has the child hurt him or herself on purpose (Cutting, Burning, Hitting, etc.)? No Yes

If yes, please briefly describe what the child experienced including any medical care received: _____

Has the child experienced or witnessed emotional abuse (e.g., chronic discord, yelling, screaming, cursing, name calling, demeaning language, financial control)? No Yes

If yes, please briefly describe the experience as well as any medial or legal involvement:

_____

Has the child experienced or witnessed physical abuse (e.g., hitting w/hands or other object; pushing; withholding food, water, sleep)? No Yes

If yes, please briefly describe the experience as well as any medial or legal involvement:

_____

Has the child experienced or witnessed sexual abuse (e.g., sexual harassment, inappropriate touching, rape, incest, etc.)? No Yes

If yes, please briefly describe the experience as well as any medial or legal involvement:

_____

Does the child currently or has the child in the past struggled with abuse or dependency of alcohol or drugs? No Yes

If yes, please briefly describe your experience (e.g., substance type used, duration of use, amount of use): _____

Does the child currently have any legal matters in his or her life? No Yes

If yes, please briefly describe your experience: _____

Is DHR currently or previously involved with the child or family? No Yes

If yes, please briefly describe the involvement: _____

Treatment Goals

What are you goals for therapy? _____

_____

_____

Any other information you would like for me to know about your child?

_____

_____

_____