Crain Counseling New Client Packet (Parent)

Childs Name: _____
Last First MI (preferred name)

Mother's name: _____ Phone Number: _____

Father's Name: _____ Phone Number: _____

Step Parents: _____

Please describe why your family is seeking counseling

_____

_____

_____

How long has this been a concern for your family? _____

How have you tried to solve this concern? _____

_____

_____

In a few words, please describe your talents, abilities and interests as a parent.

_____

_____

Community Supports

Do you currently attend a community support group [ ] Yes [ ] No
If yes, which ones (Dates/times) _____
Have you attended a support group in the past? [ ] Yes [ ] No
If yes, which ones (Dates/times)

Emotional
Areas of Personal Concern

Please Rate Only the Items You Are Currently Concerned About <u>for your Childs</u> by Placing a Number in the Box Beside the Concern
1= Mildly Upsetting 2= Moderately Severe 3=Very Severe 4= Extremely Severe 5= Totally Incapacitating

Aggression		Sexual dysfunction		Irritability		Problems at work	
Anorexia		Sexual Trauma		Obsessions/ Compulsions		Self-image	
Binging/purging		Sleep Disturbance		Poor concentration		Low self esteem	
Emotional Trauma		Feeling worthlessness		Post-traumatic stress		Desire to hurt others	
Low energy		Agitation		Self-harm		Suicidal thoughts	
Grief		Appetite change		Weight loss/gain		Marital problems	
Hallucinations		Conduct problems		Social isolation		Family problems	
Hyperactivity		Depressed mood		Substance abuse		Financial problems	
Mood swings		Elevated mood		Fearfulness		Problems with parents	
Oppositional Behavior		Emotionality		Forgetfulness		Parenting problems	
Panic Attacks		Anxiety		Anger		Co-Parenting problems	
Phobias		Guilt / Shame		Legal problems		Child discipline	
Physical Trauma		Hopelessness		Problems at school		Rejection	

Psychiatric and Behavioral Health History

1. Has your child seen a counselor before? [ ] Yes [ ] No
2. Please describe who, when, what for: _____

3. Is your child currently seeing a counselor? [ ] Yes [ ] No
4. Is your child currently under treatment of a psychiatrist? [ ] Yes [ ] No
5. Currently prescribed any psychiatric medications? [ ] Yes [ ] No
6. Please list psychiatric medications: _____
   _____

7. Please list past psychiatric medications: _____
   _____

8. Has your child been hospitalized due to a mental health condition? [ ] Yes [ ] No
9. If yes, please list dates, hospitals, and reasons: _____
   _____

10. Has your child self-harmed in the last month? [ ] Yes [ ] No
11. Where and how?_____

12. Has your child taken steps toward taking their own life in the past month? [ ] Yes [ ] No
13. When?_____

14. Do you have a family history of mental health concerns? [ ] Yes [ ] No
15. Briefly explain: _____
    _____

Trauma History

Please answer the following questions <u>for your child.</u>

1. Experienced physical abuse? [ ] Yes [ ] No
2. Experienced emotional abuse? [ ] Yes [ ] No
3. Experienced sexual abuse? [ ] Yes [ ] No
4. Experienced a sexual assault? [ ] Yes [ ] No
5. If yes to any of the above please briefly explain: _____
   _____

6. Lost a significant friend or family member to death in the last year? [ ] Yes [ ] No
7. Witnessed someone die? [ ] Yes [ ] No
8. Experienced a car accident or major accident within the last year? [ ] Yes [ ] No
9. Ever had a gun or weapon pointed/used on you? [ ] Yes [ ] No
10. Witnessed someone threatened/ harmed with a gun, knife or other weapon? [ ] Yes [ ] No
11. Lived in a war zone? [ ] Yes [ ] No
12. Been kidnaped or held against their will? [ ] Yes [ ] No

Substance Use History

1. Do you have any concerns related to substance use or abuse? [ ] Yes [ ] No
2. If yes please explain: _____

_____

Sexual Development:

1. I have concerns related to my child's sexual identity of development [ ] Yes [ ] No
2. If yes please explain: _____

_____

Medical History
Medical or Physical Concerns

Please Rate Only the Items <u>Your child</u> is Currently Concerned About by Placing a Number in the Box Beside the Concern 1= Mildly Upsetting 2= Moderately Severe 3=Very Severe 4= Extremely Severe 5= Totally Incapacitating					
	Headaches		Muscle Tension		Mental Illness
	Sleeplessness		Nausea		Gynecological Problems
	Too Much Sleep		Constipation		Recent Weight Gain
	Breathing Difficulty		Diarrhea		Recent Weight Loss
	Chest Pain		Vomiting		ADHD
	Blurred Vision		Chronic Pain		Nightmares/sleepwalking
	Fatigue		Dizziness		Chronic illness
	Unable to Relax		Feeling Panicky		Difficulty Concentrating
	Poor appetite		Stomach trouble		Sexual dysfunction
	Self-harm		Binging		Purging

Medical or Physical Concerns

Please Mark All That Apply to You or <u>your Family</u> History					
Self	**Family History**		**Self**	**Family History**	
		Hyper/Hypo Thyroid			Anxiety Disorder
		Alcoholism			Depression
		Heart Disease			Manic Depression
		Arthritis			Schizophrenia
		Asthma			Hyperactivity
		Diabetes			Chemical Addiction
		Cancer			Gambling Addiction
		Seizures			Sexual Dysfunction
		High Blood Pressure			Sexual Addiction
		Birth defects			Alzheimer's/ dementia
		Stroke			Intellectual disability

Physician Name: _____Last wellness appointment:_____
Physician Phone number: _____
Please list all current medications and reasons for use: _____

_____
Please list all known allergies: _____
Please describe any serious hospitalizations: _____

Family History
Family of Origin

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

[ ] Biological Parent [ ] Adopted parent [ ] Foster Parent
Living: [ ] Yes [ ] No Present during childhood: [ ] entire [ ] part [ ] absent [ ] NA

Describe your relationship: _____
_____

Child's Mother's Name: _____DOB/Age: _____ / _____
[ ] Biological Parent [ ] Adopted parent [ ] Foster Parent
Living: [ ] Yes [ ] No Present during childhood: [ ] entire [ ] part [ ] absent [ ] NA

Describe your relationship with your child: _____
_____

Describe child's parents' relationship: _____
_____

What did discipline look like:

[ ] Parents are married to each other
[ ] Parents are separated _____ Years
[ ] Parents are divorced ____ Years
[ ] Mother remarried _____ Times
[ ] Father remarried _____ times
[ ] Mother deceased _____ Years
[ ] Father deceased _____ Years
[ ] Mother incarcerated ____ Years
[ ] Father incarcerated __ Yea

Step-father's Name: _____ DOB/Age: _____ / _____
Living: [ ] Yes [ ] No Present during childhood: [ ] entire [ ] part [ ] absent [ ] NA
Describe your relationship: _____
_____

Step-mother's Name: _____DOB/Age: _____ /_____
Living: [ ] Yes [ ] No Present during childhood: [ ] entire [ ] part [ ] absent [ ] NA

Describe your relationship: _____

Siblings

Name	Living	Age
	[ ] yes [ ] no	
	[ ] yes [ ] no	
	[ ] yes [ ] no	

Please describe any concerns related to your children or your parenting: _____

_____

_____

_____

Spirituality and Religion

Please describe your relationship with spirituality, religion, or faith in your family: _____

_____

Socio-Economic History

Living situation

[ ] Rent apartment [ ] Rent house [ ] Own home [ ] Staying with friends/ family
[ ] facing foreclosure [ ] Facing Eviction [ ] Homeless [ ] Other

Who resides with you: _____

Education

How would you best describe your child's experience in school? (check all that apply)

[ ] Easy [ ] Moderately challenging [ ] Difficult [ ] socially hard [ ] indifferent [ ] rewarding [ ] a waste of time

School your child attends: _____ Grade: _____

Education related concerns: _____

_____

Financial

I have enough finances to cover the needs of my family [ ] Yes [ ] No
My child has awareness of our financial circumstances [ ] Yes [ ] No

Social supports

It is difficult for my child to form and maintain relationships [ ] Yes [ ] No
I can identify a group of close friends in my life to support me as a parent [ ] Yes [ ] No

Culture

The cultural my family identifies with is: _____
The Ethnicity my family associates with is: _____
The Religion my family associates with is: _____

Legal

I have concerns of my Child's legal involvement: [ ] Yes [ ] No
Please explain: _____
_____