ANCHOR OF HOPE

Thank you for choosing Anchor of Hope Counseling for your child & family. We look forward to providing services to you. We appreciate you taking the time to fill out this form completely before beginning services.

BACKGROUND INFORMATION

Child's Name: _____ **Date:** _____

Parent's Phone: ( ) _____ **Parent's Email:** _____

Address: _____

Child's DOB: _____ **Race/Ethnicity of Child:** _____

Form Completed By: _____ **Relationship to Child:** _____

CURRENT CONCERNS

Please check all the symptoms that apply to you

- ☐ Sad or unhappy most of the time
- ☐ Cries a great deal
- ☐ Decreased energy
- ☐ Feelings of being worthless/helpless
- ☐ Thoughts of suicide or self-harm
- ☐ Self-harming/cutting
- ☐ Afraid of many things

- ☐ Temper tantrums
- ☐ Lies
- ☐ Swears
- ☐ Arrogant
- ☐ Talks back to parents/adults
- ☐ Can't be trusted

- ☐ Bites nails/pulls own hair
- ☐ Lots of aches and pains
- ☐ Speech impairment
- ☐ Trouble sleeping
- ☐ Nightmares
- ☐ Sleep walking/talking

- ☐ Avoids going places/being with others
- ☐ Checks things repeatedly
- ☐ Needs things to be perfect
- ☐ Excessive or senseless worries
- ☐ Lacks confidence in abilities

- ☐ Picks on other children
- ☐ Tries to boss others around
- ☐ Has few or no friends
- ☐ Sensitive to criticism
- ☐ Afraid of rejection
- ☐ Doesn't trust other people

- ☐ Significant recent weight or appetite changes
- ☐ Hearing voices/seeing things
- ☐ Rapid mood changes
- ☐ Exhibits sexually inappropriate behaviors

- ☐ Concentration difficulties
- ☐ Needs lots of reminders
- ☐ Doesn't finish things
- ☐ Can't sit still/very active
- ☐ Easily distracted

- ☐ Hates going to school
- ☐ Often skips school
- ☐ Has conflicts with teachers and/or peers
- ☐ Problems with homework

- ☐ Immature
- ☐ Concerns with alcohol or drug use
- ☐ Runs away from home
- ☐ Steals
- ☐ Has been victim of abuse or neglect

What is the primary reason you are having your child attend counseling?

_____

_____

YOUR CHILD'S FAMILY & SUPPORTIVE RELATIONSHIPS

Are parents divorced or separated? ☐ Yes ☐ No

If yes, for how long? _____

What are the current custody/visitation arrangements? _____

_____

Please list all household/family members followed by others your child spends a significant amount of time with:

Name	Age	Relationship *(e.g. dad, uncle, friend)*	Quality of Relationship *(e.g. Good, Fair, Poor)*	Living with you? *(Y/N)*

YOUR CHILD'S BIRTH AND EARLY DEVELOPMENT

Was your child adopted? ☐ Yes ☐ No

Were there any complications with pregnancy of this child? ☐ Yes ☐ No

(I.e. premature delivery, stressful pregnancy, substance use during pregnancy)

If yes, please explain: _____

_____

Were there significant problems with this child's health or development? ☐ Yes ☐ No

If yes, please explain: _____

_____

YOUR CHILD'S LIFE STORY

What are a few areas where your child excels (strengths, favorite thing to do)?

_____

_____

_____

EDUCATIONAL HISTORY

Where does your child attend school? _____

What is the highest level of school your child has completed? _____

What have been your child's usual report card grades? _____

Has your child experienced any of the following in school?

☐ Learning Problems ☐ Discipline Problems ☐ Emotional Problems ☐ Social Problems

Has there been any academic or psychological testing done at school or elsewhere? ☐ Yes ☐ No

If yes, what were the results? _____

TRAUMA HISTORY

Have you ever had a history of trauma, abuse or neglect? ☐ Yes ☐ No

If yes, what type of abuse or trauma occurred?

☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect ☐ Verbal

PREVIOUS COUNSELING TREATMENT HISTORY

Has your child received inpatient or outpatient mental health services? ☐ Yes ☐ No

Where	When

LEGAL HISTORY

Please list any contacts your child has had with police or the court system?

_____

_____

Please list any contacts your child or family has had with Child Protective Services?

_____

_____

SUBSTANCE USE HISTORY

Has your child ever had a problem with alcohol or other drugs? ☐ Yes ☐ No

If yes, please explain: _____

_____

MEDICAL INFORMATION

Does your child have any current or ongoing medical concerns?

Please list all current medications and supplements you are taking:
(Attach another page if needed and bring list to next appointment)

Name of Medication	Dosage/Amount	Frequency

FAMILY HISTORY

Has anyone in your child's extended family had a history of mental illness? ☐ Yes ☐ No

If yes, please describe to the best of your ability (name of person, relationship to child, diagnosis)?

Has anyone in your child' extended family attempted suicide? ☐ Yes ☐ No

If yes, who?

Has anyone in your child's extended family been treated for substance abuse? ☐ Yes ☐ No

If yes, who?

OTHER

Please feel free to list any other additional information you believe would be helpful to the clinician who will be working with your child:

Completed by: **Date:**

Therapist Signature: **Date:**