Providence Counseling Center, LLC

Child or Adolescent Initial Appointment Form

Child's Name: ____ Age: ________ DOB: ____________

Sibling: ____ Age: ________ DOB: ____________

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Sibling: ____ Age: ________ DOB: ____________

1. Parent's Name: ____

   Address ____

   City, Zip ____

   Cell phone _____________________________ Marital Status? _________________________

   Email address ____

   May I leave a message at this phone number? YES NO -or at this email address? YES NO

2. Parent's Name: ____

   Address ____

   City, Zip ____

   Cell phone _____________________________ Marital Status? _________________________

   Email address ____

   May I leave a message at this phone number? YES NO -or at this email address? YES NO

3. Step Parent (s)/Guardian Name: ____

   Address ____

   City, Zip ____

   Cell phone _____________________________ Marital Status? _________________________

   Email address ____

   May I leave a message at this phone number? YES NO -or at this email address? YES NO

History of Problem

Please describe what concerns you have regarding your child:

____
____
____
____

How long has the problem existed?

____
____
____
____

Have there been any significant stressors for the family? (Losses, births, deaths, moves, hospitalizations, financial problems)

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____
____
____

What attempts have been made to resolve the difficulties?

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____
____
____

Please check the symptoms that the child is currently experiencing. Please indicate duration and severity.

Severity: 0 = None, 1 = Mild, 2= Moderate, 3 = Severe

Symptom	***Severity***	***Duration***		***Symptom***	***Severity***	***Duration***
Sadness or depression				Compulsive behaviors		
Suicidal thoughts				Feelings of hostility		
Sleep problems				Acts of violence		
Changes in appetite				Social Isolation		
Weight change				Strange thoughts		
Inability to concentrate				Stomach aches		
Obsessive thoughts				Headaches		
Anxiety or tension				Bed wetting		
Panic attacks				Phobias		
Memory problems				Other -		

Is child adopted? YES NO

If adopted, does the child know of adoption? YES NO

What was age of your child at the time of adoption? _______________

Parent Information

Are there any other agencies involved with the family? (ie. DCF, Child Welfare, Courts, etc)
____
____
____

For parents who are divorced, please state custody arrangements. (You may be required to provide legal documentation of custody arrangements.)
____
____
____

Mother's Name: _________________________________ Occupation: ______________________

Significant medical problems? ____

Current or past psychiatric treatment or counseling? YES NO

If so, regarding what issue/situation? ____

Currently prescribed medications: ____

Current alcohol/drug use: ____

History of arrests: ____

Father's Name: _________________________________ Occupation: ______________________

Significant medical problems? ____

Current or past psychiatric treatment or counseling? YES NO

If so, regarding what issue/situation? ____

Currently prescribed medications: ____

Current alcohol/drug use: ____

History of arrests: ____

Step-parent / Guardian Name: _________________________________ Occupation: ____________________

Significant medical problems? ____

Current or past psychiatric treatment or counseling? YES NO

If so, regarding what issue/situation? ____

Currently prescribed medications: ____

Current alcohol/drug use: ____

History of arrests: ____

Child Information

Child lives with: ____

School ____ Grade_______ Teacher _________________

History of counseling or psychiatric treatment ____

Current or past alcohol/drug use ____

____

____

Significant medical problems ____

____

____

Accidents or surgeries ____

____

If additional siblings will be seen:

Child's name: ____

Child lives with: ____

School ____ Grade_______ Teacher ________________

History of counseling or psychiatric treatment ____

Current or past alcohol/drug use ____

____

____

Significant medical problems ____

____

____

Accidents or surgeries ____

____

____

Child's name: ____

Child lives with: ____

School ____ Grade_______ Teacher ________________

History of counseling or psychiatric treatment ____

Current or past alcohol/drug use ____

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____

Significant medical problems ____

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____

Accidents or surgeries ____

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