

APPLICATION FOR SERVICE – MINOR CHILD

The purpose of this application is to obtain a broad picture of your child's background. In psychotherapy or counseling, records are necessary since they permit a more thorough dealing with one's problems. By completing these questions, as fully and as accurately as you can, you will facilitate your child's therapy/counseling. You are requested to answer these routine questions on your own time, so we can make better use of your actual therapy/counseling time. It is understandable that you might be concerned about what happens to the information about your child because much or all of the information is highly personal. Case records are strictly confidential and are protected as specified by law.

Child's Name		Date of Birth	Age
Street Address		City	State
/			Zip
Home Phone / Cellular	Mother's Bus. Phone / Pager	Father's Bus. Phone / Pager	
Child's Social Security Number	Name of School Attending		Grade
Person to notify in case of emergency:			
		Name	Relationship
Street Address		City	State
/		/	Zip
Home Phone / Cellular	Bus. Phone / Pager		Email Address
Mother's Occupation	Employer	Education Level	
Father's Occupation	Employer	Education Level	

FAMILY/PSYCHOSOCIAL HISTORY

Current Status of Family (check as appropriate)

Parents: Married _____(date) Divorced _____(date) Separated _____(date)

Name: _____

Name: _____

Mother: ___Birth ___Adoptive Age___

Father: ___Birth ___Adoptive Age___

Remarried to _____ Date:_____

Remarried to _____ Date:_____

Child care and visitation agreements: _____

With whom does the child live? _____

Describe your child's relationship with his/her:

Mother: _____

Father: _____

Stepmother: _____

Stepfather: _____

Please give the name and ages of any brothers, sisters, stepbrothers and/or stepsisters (if not living at child's home,

indicate where they are residing)._____

Describe your child's relationship with each of his/her brothers, sisters, stepbrothers and/or stepsisters.

FAMILY MEDICAL HISTORY:

Since many psychological difficulties may be influenced by family environment or genetics, please indicate any psychological, alcohol/drug, suicide attempts, or medical difficulties experienced by other members of your child's family:

Father_____

Mother_____

Siblings_____

Children_____

Aunts/Uncles_____

Grandparents_____

REFERRAL INFORMATION

Was your child referred by someone? Yes No If yes, who?_____

Please indicate why you are requesting services for your child, the type of difficulties she/he is experiencing, when the difficulties began, and how serious you consider them._____

MEDICAL HISTORY

Name of Child's Physician:_____ Telephone:_____

Physician's Address:_____

Do your child have allergies? Yes No If yes, what?_____

Indicate any and all medications and dosages that your child is now taking.

Medication Dose Start Date M. D. Prescribing

Does your child now have, or has she/he ever had, any physical illness or complaints? ___ Yes ___ No

Nature of Complaint _____ Age of Occurrence _____ Past or Present Difficulty _____

Does she/he smoke/chew tobacco? ___ Yes ___ No If yes, amount/day _____

Does she/he drink alcohol? ___ Yes ___ No

If yes, how much? _____ How often? _____

Does she/he use illicit drugs or abuse medications? ___ Yes ___ No

If yes, which ones? _____

How much? _____ How often? _____

PREVIOUS PSYCHOLOGICAL/PSYCHIATRIC TREATMENT

INPATIENT TREATMENT

<u>Hospital</u>	<u>Date</u>	<u>Reason</u>	<u>Outcome</u>
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OUTPATIENT TREATMENT

<u>Hospital</u>	<u>Date</u>	<u>Reason</u>	<u>Outcome</u>
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PREVIOUS MEDICATIONS

<u>Medication / Dose</u>	<u>Date</u>	<u>Response</u>
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DEVELOPMENTAL HISTORY

I. PREGNANCY/EARLY DEVELOPMENTAL HISTORY:

A. Pregnancy

1. Length of Pregnancy (weeks)_____
2. Complications with pregnancy (i.e. illness, trauma):_____
- _____
3. Medications taken during pregnancy (type/amount):_____
- _____
4. Drug/alcohol use during pregnancy (type/amount):_____
- _____
5. Smoking during pregnancy (amount/day):_____

B. Labor/Delivery

1. Labor: ___Spontaneous ___Induced Duration (hrs.):___
2. Delivery: ___Normal ___Breech ___Cesarean
3. Labor/delivery complications (e.g. prolonged, anoxia):_____
- _____
4. Birth weight:_____ APGAR:_____ Days in hospital_____
5. Child's health status at birth and first month following birth:_____
- _____

C. Developmental Information

1. (Age) Crawled:_____ Walked:_____ Talked:_____ (simple sentences)
Toilet Trained:_____ Weaned (bottled/breast-circle one):_____
- Onset of puberty:_____
2. Other Significant Developmental Milestones:_____
3. History or Enuresis (bed wetting): Age:_____ How long:_____
- History of Encopresis (soiling): Age:_____ How long:_____
4. Feeding Problems:_____ Age:_____
5. Sleeping Disturbances:_____ Age:_____
6. Hearing/Vision Problems:_____ Age:_____

II. **MEDICAL HISTORY:**

- A. Illnesses (include usual childhood diseases and state age of occurrence):_____
- _____
- _____

B. Accidents/Injuries (also state age of occurrence): _____

D. Operations/Hospitalization (give reason and age of occurrence): _____

D. Head Injuries: with loss of consciousness Age: _____ Duration: _____

w/out loss of consciousness Age: _____ Duration: _____

Details: _____

E. Convulsions: with fever without fever

Details: _____

F. Abuse (physical, sexual, emotional, verbal, abandonment/neglect) Yes No

If yes, by whom? _____ Duration: _____ Age: _____

G. Current Health Status: _____

III. PERSONAL SOCIAL INFORMATION

A. Child's Activity Level and Temperament: _____

B. Social/Peer Relationships

1. Extent and Quality of Friendships: _____

2. Preferred Activities With Peers: _____

C. Discipline

1. Major Caretaker: _____ Caretaking Arrangements: _____

2. Method of Discipline: (Mother) _____ (Father) _____

3. Child's Response to Correction: _____

D. Effective Rewards/Incentives: _____

IV. EDUCATIONAL HISTORY

A. Name of School: _____ Present Highest Grade Level Attained _____

B. School History

1. Age started 1st grade: _____

2. Started: Infant day care _____ Pre-school _____ Kindergarten _____

3. Regular/Irregular Attendance and Reason: _____

4. Grade Level(s) Retained/Advanced in and Reason: _____

5. Type of Placement (check one or more): Regular Class _____ Special Education _____
honzors _____ home study _____

6. Official School Classification (check all that apply): LD or ADHD _____ MR _____
Hearing Impaired _____ ED _____ Visually Impaired _____ Other _____

C. School Performance

1. Present grades received: _____ Past Grades Received: _____

2. Indications of Special Learning Problems: _____

3. History of Educational Testing (When, by Whom, and Results): _____

4. School Behavior: _____

List any other comments or ideas you have that may be helpful to the course of your child's therapy:

Signature of Parent/Legal Guardian

Date

In order to obtain a full and complete picture of all the things that may be of concern to you, please complete the following checklist.

CHECK any of the boxes of the following concerns that apply to you and rate its severity in the blank at the right, using the following scale:

- 1 = Mildly distressing
- 2 = Moderate
- 3 = Serious
- 4 = Severe
- 5 = Very severely distressing

Example: Family problems 3

- | | | |
|---|--|---|
| <input type="checkbox"/> Family problems___ | <input type="checkbox"/> Dawdles/lingers___ | <input type="checkbox"/> Speech difficulties___ |
| <input type="checkbox"/> Other Relationship Problems___ | <input type="checkbox"/> Daydreams___ | <input type="checkbox"/> Learning difficulties___ |
| <input type="checkbox"/> Problems at school___ | <input type="checkbox"/> Excessively dependent___ | <input type="checkbox"/> Temper outbursts___ |
| <input type="checkbox"/> Health Problems___ | <input type="checkbox"/> Sad/depressed___ | <input type="checkbox"/> Declining school grades___ |
| <input type="checkbox"/> Legal Problems___ | <input type="checkbox"/> Abuses drugs___ | <input type="checkbox"/> Conflicts with peers___ |
| <input type="checkbox"/> Makes verbal threats___ | <input type="checkbox"/> Appetite change___ | <input type="checkbox"/> Negative view of future___ |
| <input type="checkbox"/> Destroys property___ | <input type="checkbox"/> Unusual weight loss___ | <input type="checkbox"/> Suicidal thoughts___ |
| <input type="checkbox"/> Sets fires___ | <input type="checkbox"/> Unusual weight gain___ | <input type="checkbox"/> Lonely___ |
| <input type="checkbox"/> Fights with others___ | <input type="checkbox"/> Binge Eating___ | <input type="checkbox"/> No interest in things___ |
| <input type="checkbox"/> Fearful/anxious___ | <input type="checkbox"/> Soiling___ | <input type="checkbox"/> Feelings easily hurt___ |
| <input type="checkbox"/> Demanding of attention___ | <input type="checkbox"/> Bed wetting___ | <input type="checkbox"/> Lacks normal energy___ |
| <input type="checkbox"/> Withdrawn/isolated___ | <input type="checkbox"/> Lies frequently___ | <input type="checkbox"/> Poor self-esteem___ |
| <input type="checkbox"/> Disobedient___ | <input type="checkbox"/> Running away___ | <input type="checkbox"/> Skipping school___ |
| <input type="checkbox"/> Defies authority___ | <input type="checkbox"/> Nightmares___ | <input type="checkbox"/> Victim of physical/sexual abuse___ |
| <input type="checkbox"/> Poor concentration/distractible___ | <input type="checkbox"/> Sleep problems___ | <input type="checkbox"/> Quick change of moods___ |
| <input type="checkbox"/> Overactive/restless___ | <input type="checkbox"/> Conflicts with parents___ | <input type="checkbox"/> Steals___ |
| <input type="checkbox"/> Conflicts with siblings___ | <input type="checkbox"/> Self-abusive behavior___ | <input type="checkbox"/> Worries excessively___ |
| <input type="checkbox"/> Cries easily/whines___ | <input type="checkbox"/> Excessive shyness___ | <input type="checkbox"/> Critical of others___ |
| <input type="checkbox"/> Complains often___ | <input type="checkbox"/> Nervous/tense___ | <input type="checkbox"/> Other___ |

List any other comments or ideas you have that may be helpful to the course of your therapy:

Signature

Date

CONSENT TO RECEIVE SERVICES--MINOR CHILD

This will acknowledge and certify that on the date noted below, I requested Employee Assistance Program services on behalf of my child, _____. I understand that a treatment program plan will be implemented to meet the goals which have been jointly developed by myself and the counselor/therapist.

I further understand that my child's records are confidential and are protected by law. In most cases, they may not be released without my prior written consent. I have been apprised that there are some limited exceptions to confidentiality including, but not limited to, when (a) a life-threatening situation exists (suicide or homicide); (b) there is a strong suspicion of child abuse occurring in the home; (c) there is involvement in a criminal proceeding as a defendant, victim or witness.

I further acknowledge that in order for the treatment goals to be achieved, it will be my responsibility to actively support and cooperate with the treatment process. If I am not in agreement with any aspect of the process, I will bring it to the attention of my child's counselor/therapist. I understand that I am free to withdraw my child from treatment at any time.

Date

Signature of Parent/Legal Guardian

Date

Signature of Witness