CHANGING SEASONS COUNSELING INC.
A NEVADA CORP.

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503-314-8598

Client Information:

Child's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone number: _____ Cell number: _____

E-mail address: _____ Can we send you E-mails? Yes / No (circle one)

Age: _____ Date of Birth: _____ Race: _____

School: _____ Grade: _____

Family Information:

Mother's Name: _____

Phone numbers Home: _____ Cell: _____ Work: _____

May we leave messages for you at ____home ____cell ____work (check if yes for each location)

Address: _____

City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: _____ Place of employment: _____

Father's Name: _____

Phone numbers Home: _____ Cell: _____ Work: _____

May we leave messages for you at ____home ____cell ____work (check if yes for each location)

Address: _____

City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: _____ Place of employment: _____

Emergency Contact: _____ Phone: _____

Presenting concerns

Primary reason for seeking counseling services:

Check any symptoms that you are experiencing:

Depressed mood/feeling hopeless		Experienced a recent death/loss		Difficulty Concentrating/ Easily distracted	
Tearful/crying spells		Lack of energy/fatigue		Impulsiveness	
Elevated mood		Difficulties at school		Lack of enjoyment	
Running away		Perfectionism		Obsessive/Compulsions	
Feeling fearful		Physical complaints of pain		Anger outbursts	
Thoughts of self harm		Thoughts of harming others		Change in sleeping habits	
Weight changes (gain/loss)		Change in eating habits		Memory impairment	
Experiencing low self-esteem		Difficulties with family/peer relationships		Experiencing Domestic Violence	
Irritability		Feelings of Guilt/shame		Feeling anxious/nervous	
Sudden feelings of panic		Muscle tension		Violent behaviors	
Experiencing auditory Hallucinations		Experiencing visual hallucinations		Experienced a parental separation	
Feeling stressed		Pregnancy		Extreme sadness	
Excessive worrying		Social anxiety		Firesetting behaviors	
Loneliness/isolation		Mood swings		Nightmares	
Acts young for age		History of harming animals		Addictive behaviors	
Encopresis/enuresis		Headaches		Other	

Counseling History

Has your child ever been in counseling before? ____ Yes ____No

Has your child ever had a psychological evaluation? ____ Yes ____No

If yes, with whom? _____

How long was your child in counseling?_____

Has your child ever been prescribed any psychiatric medications? ____ Yes ____No

If yes, what medications? _____

What was the outcome of your child's counseling experience? _____

_____

_____

Medical History

Child's Primary Care Physician:_____ Phone Number:_____

Has your child seen their PCP within the last year? ____ Yes ____ No

If yes ____ Routine visit ____ Other (please explain) _____

_____

Is your child currently taking any prescription or over the counter medications? ____ Yes

____ No

If yes, what? _____

Has your child begun showing signs of puberty? ____ Yes ____ No

Does your child have any allergies? ____ Yes ____ No If yes, what allergies and medications taken?

_____

Developmental History

Were there any complications with the pregnancy or delivery of your child? ____ Yes ____No

Did your child meet developmental milestones (walking, crawling, talking, and toilet training)?

____ Yes ____No

Does your child have a history or current issue with speech development? ____ Yes ____No

Are there special, unusual, or traumatic circumstances that affected your child's development?

____Yes ____ No If yes, describe? _____

Has there been history of child abuse? ____ Yes ____ No

If yes, which type(s)? ____ Sexual ____ Physical ____Verbal ____ Domestic violence

If yes, the abuse was as a: ____Victim ____ Perpetrator

Other childhood issues: ____ Neglect ____ Inadequate nutrition ____ other (please specify):

_____

Briefly describe your child's temperament?_____

Briefly describe your child's relationship with Parents: _____

_____

Briefly describe your child's relationship with siblings:

_____

Additional information related to your childhood development: _____

_____

Educational History

How would you describe your child's experience at school?

_____

What are your child's favorite subjects and school activities? _____

_____

What subject does your child least enjoy and why?_____

_____

Is your child on an I.E.P. or 504 plan at school? ____ Yes ____No
Has your child ever been suspended/expelled from school? ____ Yes ____No
Does your child have a problem with skipping school? ____ Yes ____No
Does your child have many friends at school? ____ Yes ____No ____ Unknown/unsure

Substance use History

Has your child used or experimented with using tobacco (any form)? ___ Current ___ Past ____No

Has your child used or experimented with using alcohol? ____ Current ____ Past _____No

If current, How often? _____, How much? _____

Do you suspect or know that your child has used or experimented with using recreational drugs? ____ Current ____ Past _____No

If yes, has their use of substances created a problem for them at ____ home, ____school, ____ in their personal relationships?

If so, please explain further _____