

Child/Adolescent Background Information

SMU Center for Family Counseling

5228 Tennyson Parkway*Plano, TX 75024
972-473-3456 (phone)* 972-473-3490 (fax)
www.smu.edu/familycounseling

Welcome to the Center for Family Counseling at SMU! Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. Your intake counselor will discuss your responses with you after he/she has reviewed the form.

Child's Name: _____ Date of Intake: _____
Last First MI

Completed by: _____ Relationship to Child: _____
IF NOT LEGAL GUARDIAN, PLEASE STOP HERE-THANK YOU!

Child's Legal Guardian (Managing Conservator):
(If the child is not living with both natural parents, both adoptive parents, or only living parent, the Center for Family Counseling requires a photocopy of the most recent legal document stating custody arrangements, consisting of the cover page, page specifying conservator(s), and signature page). Services will not be rendered if no copy is produced.
Please initial here to indicate that you have read and understand this paragraph. _____

Child's Gender: Male__ Female__ Date of Birth: __/__/__ Age: __

Child's Ethnicity:
African American__ Bi-racial__ Hispanic/Latino__
Asian__ Caucasian__ Native American__ Other _____

Child's primary language: English__ Spanish__ Other__
Language spoken at home (parents' language): _____

CONTACT INFORMATION:

Cell Phone: _____ (May call? Yes No May Leave Message? Yes No)
Home Phone: _____ (May call? Yes No May Leave Message? Yes No)
Work Phone: _____ (May call? Yes No May Leave Message? Yes No)
Best Time and Place to call: _____

Child's Address: _____
Street City State Zip

May we correspond with you via mail at the specified above address: Yes No

In case of emergency, I authorize the Center for Family Counseling to contact: _____
Name: Last, First Relationship Phone

Person responsible for financial arrangements with our clinic: _____
Name: Last, First

Who referred you to our Center? (Please be specific): _____

May we contact this referral source to thank them for the referral: Yes No



***Please circle items you see as struggles for your child that you'd like to work on in counseling.**

Issues Related to Abuse

- Current or past physical abuse
- Current or past sexual abuse
- Current or past emotional abuse
- Current or past neglect
- History of abandonment
- Suspected sexual abuse
- History of family domestic violence

Academic/School Issues

- Learning difficulties
- Problems with peers
- Problems with teachers
- Failing grades
- Refusing to go to school
- Bullying concerns
- Peer/friend problems at school

Mood-Related Concerns

- Disturbing memories
- Difficulty going to sleep/staying asleep
- Nightmares/night terrors
- Suicidal thinking or talking
- Irritability
- Sadness/Depression
- Feelings of guilt and shame
- Excessive worrying or fear

Family Relationship Concerns

- Difficulty adjusting to family changes
- Discipline concerns
- Parent-Child relationship problems
- Sibling concerns
- Divorce/Separation
- Religious/Spiritual concerns
- Constant fighting

Rule-Breaking/Behavior Issues

- Aggression toward others
- Drug/Alcohol use
- Truancy
- Gang involvement
- Running away
- Stealing
- Intentionally hurting animals
- Fire-setting
- Other unusual behaviors (please specify) _____

Other Behavioral Concerns

- Sexual identity concerns
- Inappropriate sexual behavior
- Overeating/Refusal to eat
- Bedwetting or soiling
- Hyperactive/Impulsivity
- Inattentive
- Lying
- Oppositional/Defiant

****Please place a star by the most significant issue.***

Please briefly discuss the above behaviors you have concerns about: _____

When did you first become concerned about the main/most significant issue? _____

Why, at this point, have you decided to pursue counseling for the concern(s) above? _____

Other treatment your child has received to address any of the concerns indicated above: None ___

Group Counseling ___

Individual Counseling ___

Family Counseling ___

Hospitalization ___

Play Therapy _____

Activity Therapy _____

Other _____

GENERAL OVERVIEW

1. *Have other family members received services at this clinic?* Yes No (Name/Dates of service)



SMU.

ANNETTE CALDWELL SIMMONS
SCHOOL OF EDUCATION
& HUMAN DEVELOPMENT

2. Is your child presently receiving counseling elsewhere? Yes No
(If yes, please know we **require** a written confirmation of the therapist's consent for treatment by the Center for Family Counseling.)

3. Has your child ever seen a mental health professional (e.g., psychologist, counselor, etc.)? Yes No
(If yes, we will need your permission in order to communicate with that individual or agency).
We reserve the right to postpone services until prior treatment providers are contacted.

a. Previous Mental Health Professional/Agency: _____
Name Address

b. Phone: _____ c. Service Dates: _____ (beginning - ending)

d. Reason for seeking counseling services at that time: _____.

e. What resulted from the counseling services at that time (i.e., did you find the counseling helpful; did your child have a positive experience; how was it decided that the counseling should end, etc.)?

4. Has your child been hospitalized for mental health concerns? Yes No

a. If yes: When _____ Where _____

b. Reason for Hospitalization: _____

5. Are you seeking services because your child is a victim of a crime? Yes No

a. Did it result in legal action? Yes No (If yes, explain) _____

6. Are you seeking services for possible court advocacy (custody issues, abuse testimony, etc.): Yes No
(If Yes, explain) _____

7. Is your child currently on probation? Yes No

8. Has your child ever been suicidal? Yes No

If yes, please explain when and what happened:

9. Do you have any reason to believe your child is using substances: Yes No

If yes, please discuss:

EDUCATION INFORMATION

School child attends: _____

Current School Address & Phone: _____

Length of Time at this School: _____ How many schools has your child attended? _____



Marital Status (indicate all that apply and duration of each, ex. 1965-1985):
Never married____ Currently married____ Divorced____

Marital History
Number of Marriages____ Number of Divorces____

History of learning issues: Yes No
(If yes, please explain) _____

History of behavioral/conduct problems: Yes No
(If yes, please explain) _____

History of emotional/mental health-related issues: Yes No
(If yes, please explain) _____

History of Suicidal Attempts: Yes No If yes, please describe when and what happened:

History of Inpatient Psychiatric Care: Yes No If yes, please describe when and what happened:

History of addictions (i.e., alcohol/drug/substance abuse, gambling, computer, etc): Yes No
(If yes, please explain) _____

History of family violence: Yes No
(If yes please explain) _____

History of criminal activity: Yes No
(If yes, please explain) _____

History of protective orders: Yes No
(If yes, please explain) _____

GENERAL HOUSEHOLD INFORMATION

Child's current household(s):

- Adoptive Parents ____
- Father only ____
- Foster Family ____
- Institution ____
- Mother only ____
- Biological Father and Stepmother ____
- Biological Mother and Stepfather ____
- Biological Parents ____
- Relatives (specify) _____
- Grandparents ____

List by household your child's current family, beginning with the oldest member and include the child:

Primary Household (anyone who currently lives with child)

How long in this current living situation: _____

| Name | Age | Gender | Relationship to child (include step, half, etc.) |
|-------|-------|--------|--|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |



Second Household (non-custodial or extended family - if applicable)

Name Age Gender Relationship to child (include step, half, etc.)

Currently involved in a custody dispute: Yes No (If yes, explain) _____

If divorced, circle the number which best describes your relationship with your ex-spouse.

Hostile Frustrating Friendly
1 _____ 2 _____ 3 _____ 4 _____ 5 _____

When did the divorce occur: _____

How often does child see other parent? _____

Describe the visitation schedule:

_____(Guardian Initials) I understand I must provide the Center for Family Counseling with the most current court papers, regarding custody arrangements and agreements.

CHILD'S PHYSICAL AND MENTAL HEALTH HISTORY

Child's Primary Care Physician: _____
Name Phone

Address _____

Date of LAST complete physical: _____

Physical Disability: Yes No (If yes, explain) _____

Chronic Illness: Yes No (If yes, explain) _____

Terminal Illness: Yes No (If yes, explain) _____

Allergy History: Yes No (If yes, explain) _____

Hospitalization History (medical issues only): Please describe:

Does your Primary Care Physician know you are seeking Counseling Services? Yes No

Has your child ever seen a psychiatrist? Yes No

Is child currently seeing a psychiatrist? Yes No (If yes, list name, address and phone):

Name Phone

Address _____

What Diagnosis has your child received from a medical professional (or previous mental health professional)? (For example: TICS, ADD/ADHD, Anxiety, Depression, Conduct Disorder, Bipolar)



What medication(s) is your child currently taking (include both psychotropic, O-T-C, etc.)?

| Medication | Dosage | Taken for what reason? |
|------------|--------|------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

History of health/physical problems includes: (check all that apply):

- | | | |
|------------------------------|-------------------------|--|
| Asthma_____ | Disability_____ | Nervous stomach _____ |
| Bedwetting_____ | Dizziness _____ | Neurological problems/exam_____ |
| Bone/joint/muscle _____ | Severe Headaches _____ | Severe PMS _____ |
| Chest pain _____ | Heart Palpitations_____ | Serious overeating/under-eating__ |
| Chronic illness_____ | Hospitalization_____ | Shortness of breath without exertion _____ |
| Developmental delay(s) _____ | Major accident_____ | Sleep problems_____ |
| Chronic Diarrhea _____ | Major illness _____ | Surgeries_____ Other_____ |

Did you child experience early language/speech issues or delays? Yes No (If yes, please describe? _____)

Has your child ever lost consciousness for a period of time? Yes No (If yes, explain when, for how long, and what happened? _____)

Does your child ever stare off into space/appear to be zoned out? Yes No (If yes, please explain when and for how long? _____)

How much exercise does your child get each day (and through which activity): _____

How much caffeine does your child get each day? _____

How would you describe your child's overall diet? _____

How much sleep does your child get each day on average? _____

Are your child's sleep patterns consistent? _____

Would you describe this as restful sleep? _____

Any sleepwalking, sleep talking, night terror, nightmares? Please explain: _____

DEVELOPMENTAL HISTORY

1) Physical:

a) Pregnancy, delivery, feeding, sleep pattern, weaning, neonatal illnesses:

b) Early or significant medical illnesses or injuries (e.g., Colic, G.E.R.D., etc.):



SMU

ANNETTE CALDWELL SIMMONS
SCHOOL OF EDUCATION
& HUMAN DEVELOPMENT

- c) Neuromuscular development of speech, motor milestones (sitting, standing, walking, first words, play):
- 2) Behavioral:
- a) Toilet training and other training - response to discipline and methods used:
- b) Reactions to beginning daycare or school:
- c) Phobias/recurring fears:
- d) Habits/repeated issues (e.g., bedwetting, hair pulling, picking, thumb-sucking, etc.):
- 3) Current Level of Functioning:
- a) Social Adjustment:
- Age-appropriate peer relationship
 - Age-appropriate social etiquette
 - Age-appropriate involvement to organized groups
- b) Bathing/Dressing/Hygiene
- Independent
 - Verbal prompts
 - Requires assistance
 - Total assistance
- c) Toileting
- Enuresis
 - Encopresis
 - Independent
 - Needs Assistance
- d) Feeding
- Anorexia
 - Bulimia
 - Compulsive over-eating
 - Pica Behavior (eating inanimate objects)
 - Other
 - Normal
- e) Complex Daily Living Skills
- Age-appropriate care of possessions
 - Age-appropriate care of other's possessions
 - Age-appropriate knowledge of the use of telephone, appliances, etc.
 - Age-appropriate knowledge and applications of health issues



f) Self Harm History:

- No self-injurious behavior
- Self-harming to body
- Suicidal thoughts/comments
- Suicidal attempts

g) Substance Abuse Concerns:

- Has tried smoking
- Smokes regularly
- Has tried alcohol once or twice
- Has tried alcohol frequently
- Has tried other drugs, such as: _____
- Has not admitted to any use, but I have reason to believe or am concerned about this

h) Sexual Acting-out

- Has given NO indication of issues or concerns in this area
- Has discussed wanting to become sexually active; explain: _____
- Has admitted to trying sexual activity; explain: _____
- Engages in sexual activity frequently; explain: _____

4) Child's Daily Life Schedule (Please give general schedule from day-to-day of how your child spends his/her time):

- Monday: _____
- Tuesday: _____
- Wednesday: _____
- Thursday: _____
- Friday: _____
- Saturday: _____
- Sunday: _____

HISTORY OF STRESSORS RELATAED TO THE CHILD

(For each of the following items that apply, write in your child's approximate age at the time it occurred if it applies to your child):

- Chronic illness of family member _____ Death of significant person _____ Domestic Violence _____
- Family member absent (explain) _____
- Family member's disability/major accident/illness _____
- Family member emotional problems (explain) _____
- Family member suicide (explain) _____
- Parent's divorced _____
- Child separated from parent (how long and when) _____
- Death of a pet _____ Difficult medical treatments _____ Natural Disaster _____
- Sexual Assault _____ Other trauma (an unusual, terrifying experience) _____
- Other life altering/Changing experience _____
- Other general experiences that may have impacted your child significantly: _____



HOME ATMOSPHERE

Other significant relationships, in addition to the family discussed above: _____

Name and discuss child's relationship with pets that live in the home: _____

Child's chores or household expectations: _____

How does your child do in meeting those expectations? _____

How much does your child get to play/be with friends? _____

How does your child do in playing/interacting with other children? _____

Can your child make friends? Yes No; Please Explain: _____

Can your keep friends? Yes No; Please Explain: _____

Your child's current use of computer and television (circle the number of hours that best describes use):

Computer (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

TV (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

I agree that the above information is accurate to the best of my ability. I also understand that if I have any questions regarding the above questions, I can ask my screening/intake counselor at any time. I also understand that completing this intake does not guarantee that counseling services will be rendered at this Center.

Client/Guardian

Date

