Life Wellness & Chiropractic PC

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Please answer the questions below about your child as honestly and completely as possible so that we might know how to best support you and your child on your therapeutic journey.

Client's Name: _____ Date of Birth: _____

Address: _____

Telephone: _____ May we leave a message? ___ Y ___ N

Parent/Legal Guardian(s): _____

Is there any other party which currently shares legal custody? If so, please name:

_____

Referral Source: _____

*I hereby certify that the content disclosed within these pages is accurate and complete to the best of my knowledge.

_____

Parent/Legal Guardian Signature Date

Reason for seeking counseling services:

_____

_____

_____

What would you like to see different about your child or your family as a result of being in therapy?

_____

_____

_____

Please include names of providers, dates of care, and locations in answer to the following:

Prior Counseling Experience:

_____

_____

_____

Inpatient/Psychiatric Hospitalizations:

Past Psychiatric Medications:

Current Psychiatric Medications:

Prior Mental Health Diagnoses:

Which of the above has been helpful for your child/your family?

What has not been helpful? Why not?

Physical Health Challenges and Treatment:

Significant Health History:

Is your child challenged by developmental delays? If so, explain.

Describe your child's experience with academics:

Describe your child's experience interacting with peers:

Describe your child's experience interacting with authority figures including parents, teachers, etc. and following rules:

_____
_____
_____

Family history/makeup:

_____
_____
_____

What does your child like to do for fun?

_____
_____
_____

Current Symptoms: (Check all that apply)

___ Long periods of sadness	___ Intrusive memories	___ Relationship difficulties
___ Loss of interest	___ Racing thoughts	___ Mood swings
___ Fatigue	___ Physical pain	___ Startle easily
___ Change in sleeping or eating	___ Memory challenges	___ Hearing voices
___ Nightmares	___ Thoughts of suicide	___ Spacing out/blacking out
___ Loss of time	___ Self-harm behavior	___ Anger
___ Feeling disconnected from body	___ Substance Abuse	___ Seeing things others don't
___ Difficulty expressing emotions	___ Difficulty following rules	___Aggression toward others
___ Aggression toward animals	___ Destruction of Property	___ Change in school work
___ Change in toileting habits	___ Separation Anxiety	___ Learning Disability
___ Attention challenges	___ Hyperactivity	___ Eating of non-food items

___ Other (please list) _____

To the best of your knowledge, is your child now experiencing, or has he or she ever experienced, any of the following events? If yes, please list BRIEFLY when and with whom.

___ Y ___ N Physical Assault or Abuse

_____
_____

___ Y ___ N Sexual assault or Abuse

_____
_____

___ Y ___N Emotional or Verbal Abuse

_____

_____

___ Y ___N Parental Neglect

_____

_____

___ Y ___ N Domestic Violence

_____

_____

___ Y ___ N Violent Crime

_____

_____

___ Y ___ N Ritual Abuse or Torture

_____

_____

___ Y ___ N Grief and Loss

_____

_____

___ Y ___ N Natural Disaster

_____

_____

___ Y ___ N Involvement with DFCS or the Legal System

_____

_____

Other Traumas (please list) : _____

How do you believe these experiences have affected your child and your family?

_____

_____

_____

Is there anything else we need to know in order to be most helpful to your child and your family?

_____

_____

_____