Healing Counseling Center Inc.

8751 Collin McKinney Parkway #205
McKinney TX 75070-1658
940-220-9307

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6. Child/Adolescent Background Information

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DATE OF INTAKE APPOINTMENT ::

CHILD NAME::

FORM COMPLETED BY::

RELATIONSHIP TO CHILD::

Welcome to the Healing Counseling Center INC.! 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 counselor will discuss your responses with you after he/she has reviewed the form.

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, Healing Counseling Center 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 NAME::

CHILD DATE OF BIRTH::

CHILD GENDER::

CHILD ETHINICITY::

CHILD PRIMARY LANGUAGE::

PRIMARY LANGUAGE SPOKEN AT HOME::

CONTACT INFORMATION:
We will leave a general voicemail message at any phone number listed below. If you do not wish us to leave a message, please do not provide that phone number

CELL PHONE::

WORK PHONE::

HOME PHONE::

BEST TIME AND PLACE TO CALL::

ADDRESS- PLEASE INCLUDE CITY/STATE/ZIP:

May we contact you at the above address?:

In case of Emergency I authorize Healing Counseling Center to Contact the following person/persons::

PERSON RESPONSIBLE FOR FINANCIAL OBLIGATIONS WITH OUR CLINIC::

WHO REFERRED YOU TO OUR CENTER, PLEASE BE SPECIFIC.:

May we contact the referral source to thank them for the referral?:

*Please check the 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 neglect
- [ ] History of abandonment
- [ ] Suspected sexual abuse
- [ ] History of family domestic violence

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

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)

Please Specify::

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

Family Relationship Concerns:

- [ ] Difficulty adjusting to family changes
- [ ] Discipline concerns
- [ ] Parent-Child relationship problems

- [ ] Sibling concerns
- [ ] Divorce/Separation
- [ ] Religious/Spiritual concerns
- [ ] Constant fighting

Other Behavioral Concerns

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

Of the boxes checked above what is 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?:

General Overview

Have other family members received services at this clinic? If yes please state names and dates of service/treatment.:

Is your child presently receiving counseling elsewhere? (If yes, please know we require a written confirmation of the therapist's consent for treatment by Healing Counseling Center.):

Has your child ever seen a mental health professional (e.g., psychologist, counselor, etc.)? (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.:

Previous Mental Health Professional/Agency::

Dates of Mental Health service::

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

Medication / Dosage / Reason/:

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.

Parent/Guardian Name::

Date::