2nd Star Counseling, LLC

www.2ndstarcounseling.com

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Child/Adolescent Information

Child's Name: _____ **Child's Age:** _____
Guardian's Name (1): _____ **Relationship to Child(ren):** _____
DOB: _____ **Gender:** _____ **Marital Status:** _____
Home Number: _____ **Cell Number:** _____ **Work Number:** _____
Permission to Leave Messages? _____ **Email:** _____
Home Address: _____
(Address) *(City)* *(State)* *(Zip)*
Occupation: _____ **Employer:** _____

(if applicable)
Guardian's Name (2): _____ **Relationship to Child(ren):** _____
DOB: _____ **Gender:** _____ **Marital Status:** _____
Home Number: _____ **Cell Number:** _____ **Work Number:** _____
Permission to Leave Messages? _____ **Email:** _____
Home Address: _____
(Address) *(City)* *(State)* *(Zip)*
Occupation: _____ **Employer:** _____

Guardianship:

Who has legal guardianship of the child seeking counseling?	
If different than biological parent, a copy of the order granting guardianship must be provided prior to the first session. *I acknowledge that both natural parents, even though separated/ divorced, may have a right to obtain from the provider named below information regarding the nature and course of treatment of the child(ren).*	

Primary Family Members:

Name	*Age*	*Relationship to child seeking counseling*

School Information:

Child	*Grade*	*Name of School*

Child's School _____

School address/Phone number _____

Who is your child's primary teacher? _____

Has your child experienced any difficulties in school? Yes No

If yes, please describe: _____

Medical/Mental Health History:

Has your child previously received mental health services? Yes No

If yes, indicate name of professional and dates of service: _____

When your child's last medical examination and what was the reason for the examination? _____

Does your child drink alcohol or use recreational drugs (if you know)? Yes No

If yes, please describe the nature and frequency of use: _____

Please list any mediations that are currently prescribed to your child and the reasons for taking such medication:

Medication Name:	Taken For:	Prescribed By:

Does your child have, or have they ever had, any medical conditions I should be aware of? Yes No

If yes, please describe: _____

Were there any significant difficulties during pregnancy/childbirth? Yes No
If yes, please describe:

Please circle any of the following that pertain to your child:

Nervousness	Depression	Fears
Shyness	Intrusive Thoughts	Suicidal Thoughts
Separation	Divorce	Finances
Drug Use	Alcohol Use	Friends
Anger	Self Control	Unhappiness
Sleep	Stress	Work/School
Relaxation	Headaches	Tiredness
Legal Matters	Memory	Ambition
Decreased Energy	Insomnia	Making Decisions
Loneliness	Inferiority Feelings	Concentration
Nightmares	Appetite	Health Problems
Stomach/Bowel Trouble	Self-harm (cutting, etc.)	Separation Anxiety
Sudden Weight Gain/Loss	Change in sleeping patterns	Allergies
Aggression	Bed Wetting/Soiling	Truancy
Other:		

Please list any extracurricular activities/sports that your child participates in:

What are the primary issues/reasons for seeking counseling at this time?

How long have these issues been affecting your child?

Where are the problems observed most (home, school, work, etc…)?

What do you hope your child will accomplish in counseling?

What does your child hope to accomplish in counseling (if applicable)?

Is there anything else you want me to know at this time?

Guardian Signature: _____ *Date:* _____

Guardian Signature: _____ *Date:* _____

Witness Signature: _____ *Date* _____