Date Completed: _____ Client ID#_____

INITIAL SERVICE CONSULTATION (MINOR)

BACKGROUND INFORMATION

CHILD:

First and Last Name: _____

DOB: _____ Sex: ☐ Male ☐ Female ☐ Other

Race: _____ Hispanic/Latino: ☐ YES ☐ NO

PARENT(S)/LEGAL GUARDIAN(S):

Parent/Guardian #1
First and Last Name: _____

DOB: _____ Sex: ☐ Male ☐ Female ☐ Other Relation to Child: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-mail_____

Please check your employment status: ☐ Full-time ☐ Part-Time ☐ Unemployed ☐ Not in Labor Force

Please check your military status: ☐ None ☐ Active Duty ☐ Military Dependent
☐ Veteran – honorable discharge ☐ Veteran – dishonorable discharge

Parent/Guardian #2
First and Last Name: _____

DOB: _____ Sex: ☐ Male ☐ Female ☐ Other Relation to Child: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-mail_____

Please check your employment status: ☐ Full-time ☐ Part-Time ☐ Unemployed ☐ Not in Labor Force

Please check your military status: ☐ None ☐ Active Duty ☐ Military Dependent
☐ Veteran – honorable discharge ☐ Veteran – dishonorable discharge

Is there a custody decree/legal guardianship in place?* ☐ YES ☐ NO
>If yes, who is responsible for medical/mental health decision making?
☐ Parent #1
☐ Parent #2
☐ Joint
*We will need copy of your custody decree/legal guardianship prior to scheduling counseling services.

Client ID#_____

PRESENTING PROBLEM

Please write a couple of sentences concerning the reason for your request of services.
NOTE: At this time, we only provide counseling services for grief related problems stemming from a death, anticipated death, pregnancy loss, and infertility.

_____

_____

_____

When did these problems start? _____

How intense are these problems? _____

How often are they a problem? _____

Has there been changes or difficulties in: ☐ Mood ☐ Sleep ☐ Appetite ☐ Concentration ☐ Substance Use ☐ Anger/Aggression ☐ Social withdrawal ☐ Anxiety

What other stressors are present? (e.g., poverty, court proceedings, DHS involvement, legal involvement, safety concerns)

_____

_____

_____

Reminder…

Treatment Providers CANNOT:

- Go to court
- Provide opinions or recommendations to the court, GAL, DHS, or other entity
- Be investigative

Treatment Providers CAN:

- Communicate facts only to attorneys, GAL's or other entities ONLY WHEN an authorization to release confidential information is signed.

CURRENT LIVING SITUATION

Child lives (check one): ☐ With family ☐ Foster home ☐ Other: _____

OTHER CHILDREN LIVING IN THE HOME

Name: _____ DOB: _____ ☐ M ☐ F ☐ Other

Name: _____ DOB: _____ ☐ M ☐ F ☐ Other

Name: _____ DOB: _____ ☐ M ☐ F ☐ Other

Client ID#_____

Name: _____ DOB: _____ ☐ M ☐ F ☐ Other

OTHER ADULTS LIVING IN HOME

Name: _____ DOB: _____ ☐ M ☐ F ☐ Other

Relationship to Child: _____

Name: _____ DOB: _____ ☐ M ☐ F ☐ Other

Relationship to Child: _____

PHYSICAL/MENTAL HEALTH

Please list all current medications taken for physical or mental health: **If none, check here:** ☐

Medication	Strength & Dose	Duration	Reason

Mental Health
Please indicate any biological family history of mental health issues: **If none, check here:** ☐

☐ Post-Traumatic Stress Disorder (PTSD) – If yes, whom: _____

☐ Personality Disorder – If yes, whom: _____

☐ Schizophrenia – If yes, whom: _____

☐ Hallucinations (visual or auditory) – If yes, whom: _____

☐ Substance Abuse – If yes, whom: _____

☐ Addiction – If yes, whom: _____

☐ Depression Postpartum Depression – If yes, whom: _____

☐ Anxiety – If yes, whom: _____

☐ ADD/ADHD – If yes, whom: _____

☐ Bipolar Disorder – If yes, whom: _____

☐ Violence – If yes, whom: _____

☐ Other: _____

Was your child exposed to drugs/alcohol during pregnancy? ☐ YES ☐ NO

>If yes, please describe mother's use (e.x., what substance, how often):_____

_____

Is your child currently or have you ever suspected that your child experiences hallucinations (auditory or visual)? ☐ YES ☐ NO

Has your child ever been diagnosed with a mental illness? ☐ YES ☐ NO

>If yes, please list: _____

>If yes, by whom: _____

Is your child currently receiving behavioral/mental health services elsewhere? ☐ YES ☐ NO

>If yes, please indicate:

Provider: _____ Reason: _____

Has your child received behavioral/mental health services in the past? ☐ YES ☐ NO

>If yes, indicate:

When: _____ Provider:_____

Reason: _____ Reason Ended: _____

Physical Health

Is your child currently under the care of a physician for medical problems/chronic illness? ☐ YES ☐ NO

>If yes, describe:_____

Is your child currently smoking cigarettes, vaping, or use other tobacco products? ☐ YES ☐ NO

>If yes, please describe amount, frequency, and type:

_____

>If yes, would you like treatment to reduce or eliminate the use of tobacco products? ☐ YES ☐ NO

Is your child drinking alcohol? ☐ YES ☐ NO

>If yes, please describe amount, frequency, and type:

_____

>If yes, would you like treatment to reduce or eliminate their use of alcohol? ☐ YES ☐ NO

Is your child currently using other substances? ☐ YES ☐ NO

>If yes, please describe amount, frequency, and type:

_____

>If yes, would you like treatment to reduce or eliminate your use of other substances? ☐ YES ☐ NO

EDUCATIONAL

What is your child's current grade? _____ Is he/she performing at grade level? ☐ YES ☐ NO

Has your child been diagnosed with an intellectual, development, learning or other disability? ☐ YES ☐ NO

>If yes, please indicate diagnosis: _____

Has your child ever received special education services? ☐ YES ☐ NO

>If yes, please indicate age and type: _____

_____

Does your child currently have an IEP or 504 Plan? ☐ YES ☐ NO

>If yes, please describe. _____

_____

How would your child's teacher(s) describe your child? _____

_____

What concerns do you have regarding your child's academic performance? _____

_____

In the past 90 days, how many days has your child been absent from school?_____

>If over 0, what were the reasons?_____

In the past 90 days, how many days has your child been suspended from school?_____

>If over 0, what were the reasons?_____

In the past 90 days, how many days has your child not been allowed to return to daycare? _____

>If over 0, what were the reasons?_____

SOCIAL

What are your child's hobbies? _____

Describe your child's social involvement (i.e., sports, boy/girl scouts): _____

_____

How would you describe your child's social relationships? _____

_____

What concerns do you have regarding your child's social development? _____

_____

Is your child employed outside of the home? ☐ YES ☐ NO

>If yes, please describe. _____

_____

TRAUMA/ADVERSE CHILDHOOD EXPERIENCES (ACES)

Please indicate whether your child has experienced any of the following at any point in life:

☐ YES ☐ NO Has your child ever had any adult in their life who would *often*:

Swear at your child, insult your child, put your child down or humiliate them?
OR
Act in a way that made your child afraid that they might be physically hurt?

☐ YES ☐ NO Has your child ever had any adult in their life who would *often*:

Push, grab, slap, or throw something at your child?
OR
Ever hit your child so hard that he/she had marks or were injured?

☐ YES ☐ NO Has your child ever had any adult or person 5 years older in their life who *ever*:

Touch or fondled him/her or have him/her touch their body in a sexual way?
OR
Tried to actually have oral, anal, or vaginal sex with him/her?

☐ YES ☐ NO Does your child o*ften* feel:

No one in the family loves him/her or thought he/she was important or special?
OR
Your family doesn't look out for each other, feel close to each other, or support each other?

☐ YES ☐ NO Does your child *often* feel that:

He/she doesn't have enough to eat, has to wear dirty clothes, and has no one to protect them?
OR

His/her parents were too drunk or high to take care of you or take you to the doctor if you needed it?

☐ YES ☐ NO Has your child's parents ever separated or divorced?

☐ YES ☐ NO Has your child's parent…

Often been pushed, grabbed, slapped, or had something thrown at him/her?
OR
Sometimes or *often* been kicked, bitten, hit with a fist or with something hard?
OR
Ever been repeatedly hit over at least a few minutes or threatened with a gun or knife?

☐ YES ☐ NO Does your child currently or has your child ever lived with anyone who was a problem drinker, alcoholic, or who used street drugs?

☐ YES ☐ NO Was a household member depressed or mentally ill or did a household member attempt suicide?

☐ YES ☐ NO Did a household member ever go to prison?

Please share any other traumatic incidents your child has experienced:

_____

_____

_____

_____

_____

RISK FACTORS

Self-Harm

Has your child ever expressed thoughts of self-harm (e.x. cutting, burning)? ☐ YES ☐ NO

>If yes, identify month & year of most recent thought(s): _____

Has your child ever engaged in self-harm? ☐ YES ☐ NO

>If yes, identify month & year of most recent act(s):_____

Suicide

Has your child ever expressed thoughts of suicide? ☐ YES ☐ NO

>If yes, identify month & year of most recent thought(s): _____

Has your child ever attempted suicide? ☐ YES ☐ NO

>If yes, identify month & year of attempt(s):_____

Homicide

Has your child ever expressed thoughts of homicide? ☐ YES ☐ NO

>If yes, identify month & year of most recent thought(s) and toward whom: _____

_____

Has your child ever attempted homicide? ☐ YES ☐ NO

>If yes, identify month & year of attempt(s):_____

Violence

Has your child ever been charged with a violent crime? ☐ YES ☐ NO

>If yes, please describe: _____

Running Away

Has your child ever ran away? ☐ YES ☐ NO

>If yes, how many times and when was the last time? _____

_____

>If yes, what was the trigger? _____

_____

STRENGTHS & SUPPORTS

What is your child good at? _____

_____

What do you enjoy about your child? _____

_____

_____

Describe your child's support system: _____

_____

_____

Describe your family's faith or spirituality: _____

_____

Is there any other information you feel is important for us to know? _____

_____

_____