Rock of Hope Counseling

105 Clayview Drive
Liberty, MO 64068

Child & Family Information

Please fill out this form completely. If there is information that you do not know, or cannot obtain, write in the word "unknown". This information will be treated in a strictly confidential way.

Date completed _____

Child's name: _____ Sex: M F

Date of Birth _____ Age ____ Cell Phone_____ Ok to text? Y N
(for scheduling purposes only)

Present address _____
Number Street City State Zip

Ok to send mail to this address: Yes ☐ No ☐

Home phone _____Business or cell phone of parent(s)_____
Ok to text? Y N (for scheduling purposes only)

Religious Preference_____ Spirituality included in counseling? Y N

Parent/Guardian's Name _____

Biological or Adopted _____ If adopted, child's age at adoption _____

Child's Ethnic Background_____

Primary Language spoken in the home_____

If child is not currently living with both natural parents:

Is either natural parent deceased? ____ If so, when? _____

Were parents married? _____ When? _____

Have parents separated? _____ When? _____

Have parents divorced? _____ When? _____

Other marriages? _____

Briefly explain any special living circumstances (foster-care, custody arrangements, visiting rights, etc.)_____

_____

_____

How long has the child resided at the present address? _____

Does the child share a bedroom with anyone? Y N If yes, with whom? _____

Education

Child's School _____ # Years attended _____Grade _____

Teacher _____ School Counselor _____

Who referred you to this office? _____

Client Information

Has your child had any counseling or are they currently in any type of counseling? ____

Name, address and phone number of current therapist_____

_____

How successful did you find previous counseling? _____

_____

Is child currently seeing a psychiatrist? Y N

If yes, name, address and phone # of psychiatrist _____

_____

Is child taking any medications? Y N

If yes, what type of medication does child take and what is the medication for?

_____

_____

Does it help? _____

When was child's last physical exam? _____ Given by whom? _____

What were the results? _____

_____

****Counselor: If it has been over a year or if presenting symptoms could possibly be the result of a medical issue, suggest that the parents take child in for a check up**

Presenting Concerns

What is your main concern about your child? _____

_____

_____

How long has this concern existed? _____

In what setting does it occur? (circle all that apply)

Home School Church Sports Neighborhood Public places Other_____

Does this child have any academic concerns? Y N

If yes, please explain _____

_____

Has he/she ever repeated a grade? _____ Which grade? _____

Has there been any abuse of the child? (please circle all that apply)

Physical Verbal Sexual Neglect

Please explain anything that was circled _____

_____

_____

Would this child say that he/she had many friends? Y N

Please explain _____

_____

Would other adults who observe this child say he/she had many friends? Y N

Please explain _____

_____

What are the typical difficulties this child has with brothers and/or sisters?

_____

How does the child express anger? _____

Was there a time when the child seemed to be doing well in school and/or home? Y N

Describe_____

_____

What does the child do well?_____

_____

How will you know that things are changing as the process is ongoing? _____

_____

What do you expect will be different when therapy is completed?

_____

Developmental History

Pregnancy and Delivery:

Length of pregnancy: _____ weeks Birth weight: _____ lbs, _____ oz

Please describe any pregnancy or birthing complications: _____

_____

_____

Drug/Alcohol use during pregnancy? Y N

If yes, please explain: _____

_____

Early Childhood: Check one in each column indicating when child showed development in each area.

CHILD WALKED	CHILD SPOKE WORDS	SPOKE SENTENCES
__ less than 12 months	__less than 12 months	__less than 12 months
__ 12-24 months	__12-24 months	__ 12-24 months
__24-36 months	__24-36 months	__ 24-36 months
__ over 36 months	__ over 36 months	__ over 36 months
__has never walked	__ has never spoken words	__ never spoken sentences

CHILD FIRST TRAINED FOR URINATION	CHILD FIRST TRAINED FOR BOWELS
__less than 12 months	__ less than 12 months
__ 12-24 months	__ 12-24 months
__ 24-36 months	__ 24-36 months
__ 3-5 years	__ 3-5 years
__ over 5 years	__ over 5 years
__ not yet trained	__ not yet trained

SINCE INITIAL TOILET TRAINING	SINCE INITIAL TOILET TRAINING
____ frequent wetting during day	____ frequent soiling during day
____ frequent wetting during night	____ frequent soiling during night

Explain any of the above: _____

_____

_____

Puberty: Onset of puberty (breast development, menstruation, pubic hair, facial hair)

___ under 10 years	___ 14-16 years
___ 10-12 years	___ over 16 years
___ 12-14 years	___ no development

Illnesses and Diseases: Please check any illness or disease which child has had.

__ asthma
__ eczema
__ arthritis
__ diabetes
__ cancer
__ anemia
__ measles
__ mumps
__ chickenpox
__ diphtheria
__ scarlet fever
__ polio
__cerebral palsy
__ lead poisoning
__encephalitis
__ tuberculosis
__ heart disease
__ influenza
__ pneumonia
__ migraine headaches
__ undescended testicles
__ high blood pressure
__ low blood pressure
__ sinusitis
__ appendicitis
__ heart surgery
__ tonsillectomy
__ convulsions
__ brain injury
__ fainting
__ dizziness
__ meningitis
__ broken bone
__ others (write in)
_____
_____
_____
_____
_____

List any medications your child is currently taking:

_____

_____

Hospitalizations: Please list any hospitalizations, age and length of stay.

Condition for which hospitalized	Age	Length of stay
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social & Behavioral: Please check the items the child has difficulty with.

☐ Auditory	☐ focus on objects; not people	☐ physical aggression
☐ bed wetting	☐ forgets	☐ rocking body
☐ blanking out	☐ giving up	☐ shyness
☐ breath holding	☐ habits	☐ sibling conflict
☐ can't fall asleep	☐ head banging	☐ sleep walking
☐ clumsiness	☐ hyperactivity	☐ social isolation
☐ constipation	☐ impulsively	☐ slowness to learn
☐ coordination	☐ interrupted sleep	☐ soiling
☐ dangerous behavior	☐ mannerisms	☐ speech
☐ daredevil behavior	☐ nail biting	☐ stubbornness, rigidity
☐ diarrhea	☐ night terrors	☐ tantrums
☐ early waking	☐ nightmares	☐ thumb sucking
☐ eating	☐ verbal aggression	☐ fears
☐ vision	☐ other language	☐ other (describe)

Family History

Check all of the following family concerns that apply currently or in the last 6 months:

Marital difficulties	____	Older sibling leaving home	____
Aging grandparents	____	Recent death in family	____
Addictions (Alcohol, etc.)	____	Recent death of friend	____
Serious illness of child	____	Drug addiction in family	____
Serious illness relative	____	Financial problems	____
Birth of a sibling	____	Step parent in the home	____
Move to a new house	____	Traumatic experience	____
Move to a new school	____	Other (specify) _____	

Has there been anyone in either parent's family who has been treated for mental illness?

Y N If yes, please explain: _____

_____

_____

Has anyone in either parent's family been prescribed medication for depression, bipolar disorder, or anxiety?

Y N If yes, please explain: _____

_____

_____

Has anyone in either parent's family been treated for alcoholism, sexual addiction or drugs?

Y N If yes, please explain: _____

_____

_____

Describe briefly any special interests, hobbies and recreational activities in which family members participate:

Child: _____

_____

Mother: _____

_____

Father: _____

_____

Brothers/Sisters: _____

_____

Please list all those living in child's home:

Name	Relationship	Birth date	Occupation

Please list all other persons closely involved with child but not living in home:

Name	Relationship	Place of Residence

Describe an important family value_____

_____

How would you describe the child as a person? _____

_____

Name of adult completing this form: _____

Relationship to child _____

Counselor Signature _____ Date _____