CY-HOPE COUNSELING
The Center for Children and Families

12715 Telge Rd.
Cypress, TX 77429
713.466.1360
www.cy-hopecounseling.org

Please complete the following questions about your child or adolescent prior to initial appointment.

DATE: ___/___/___

PATIENT NAME: _____ **BIRTH DATE:** ___/___/___ **AGE:** _____

NICKNAME(S): usually used_____ **SEX:** Male ☐ Female ☐

LEGAL GUARDIAN(S): _____

NAME OF PERSON(S) COMPLETING THE FORM: _____

RELATIONSHIP TO CHILD/ADOLESCENT: _____

SYMPTOM CHECKLIST INSTRUCTIONS: Please read each item carefully. If an item applies to the child or adolescent now or in the past, please check the item.

BEHAVIOR			Trouble concentrating
	Does things without thinking		Feels sad often / cries easily
	Refuses "no" for an answer		Does not seem to feel guilt
	Destroys property or belongings		Is extremely critical
	Steals		Seems afraid to make mistakes / easily embarrassed
	Lies often		Does not like to be touched
	Has been in trouble with police or probation		Resents even gentle criticism
	Sexual problems		Has an "I don't care" attitude
	Has run away from home		Has a "you cannot make me" attitude
	Has attempted or talked about suicide		Feels angry often
	Argues when told to do something		Feels bored often
	Delays doing as asked		Is afraid of "rough" play
	Cruel to animals		Has frequent nightmares
	Wants everything his/her own way		Other:
	Often tries to be the center of attention	**FAMILY**	
	Has temper tantrums or violent behavior		Sleeps in bed with parents
	Acts like a younger child		Avoids contact with family members
	Curses		Parents get along poorly with each other
	Sets fires		Clings to parents
	Nervous habits / anxiety / panic attacks		Other:
	Often pouts and sulks	**SOCIAL**	
	Prefers to be alone / avoids activities		Hangs around with a bad crowd
	Other:		Is too easily led by others
ACADEMIC			Chooses younger friends ____ older friends ____
	Is truant from school		Is often teased by others
	Does not complete assignments in classroom		Does not like being alone
	Does not do homework		Has few friends
	Feels unfairly treated by teachers or authorities		Tattles on other children
	Short attention span		Teases other children
	Often clowns around in class		Seems shy
	Refuses to go to school		Often boasts
	Is poorly organized in seat work		Often interrupts others
	Poor handwriting / sloppy work		Will note argue or fight back when most would
	Cannot sit still		Fights
	Makes grades below ability		Has EVER been sexually molested
	Has difficulty working in groups		Uses alcohol
	Rarely speaks up in the class		Uses drugs
	Rarely works without individual attention		Sells drugs
	Test anxiety		Smokes cigarettes
	Fears teacher(s)		Other:
	Trouble on the bus	**PHYSICAL**	
	Other:		Frequent physical complaints

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THINKING / ATTITUDE			
	Seems preoccupied with certain thoughts		Is tired much of the time____
	Daydreams more than most		Is seriously overweight ____ underweight ____
	Says or does things over and over		Lost weight ___ Gained weight _____
	Hears or sees things that are not there		Hearing problems ____ Speech problems ____
	Seems unaware of what is happening		Vision problems
	Lacks self-confidence		Poor bladder control days___ nights___ wets bed ___

1. DESCRIPTION OF GOALS:

What behaviors and talk will you see and hear after things are better? Include what will be different for child and family. (For example: "We will be talking through problems without yelling at each other.")

a. _____

b. _____

c. _____

2. FAMILY INFORMATION:

a. Is the child **ADOPTED?** No ☐ Yes ☐ If yes, age of child when adopted: _____

Is the child a **FOSTER CHILD?** No ☐ Yes ☐ If yes, list caseworker's information:

Caseworker's Name: _____ Phone: _____ County: _____

b. CHILD'S BIOLOGICAL PARENTS ARE NOW:

☐ **Never Married** ☐ and together ☐ and separated, list date separated: _____

☐ **Married** How many years? _____

☐ **Separated** Date separated: _____

☐ **Divorced** Date divorced: _____

Has either parent remarried? No ☐ Yes ☐ If yes, when: _____

☐ **Deceased** List relationship and date deceased: _____

c. CUSTODY AND VISITATION:

If divorced or separated, what is the custody arrangement and what is the visitation arrangement? How well do these arrangements work?

Per ethical rules, copy of custody agreement required before seeing child.

☐ Not applicable

3. CARETAKERS / OTHER IMPORTANT PERSONS:

List parents, siblings (biological, step, or adoptive), and other important persons who are not currently in the home:

NAME	AGE	CITY	RELATIONSHIP	FREQUENCY SEEN

Describe how the child gets along with the above persons:

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4. SIBLINGS AND OTHER IMPORTANT FAMILY ?

Family Member/ Significant Other/ Other	Age	Living with patient?	Relationship to patient	Occupation
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		

Describe how the child gets along with the above persons:

5. SOCIAL AGENCIES: Please list any welfare, children's services connections, or social agencies, such as CPS involved with your family: None ☐

6. PATIENT HEALTH INFORMATION:

a. BIRTH WEIGHT: _____

Any problems with the pregnancy or delivery? No ☐ Yes ☐ If yes, please describe:

b. DEVELOPMENTAL MILESTONES: (List any problems below)

Infancy: Birth to two years. List any significant delays / problems such as feeding problems or slow to walk or talk: None ☐

Toddler / preschool: 2-5 years. List any developmental delays or difficulties such as trouble with toilet training, speech, or self-care: None ☐

School age: 8-12 years. Describe any delays or problems such as attention problems, refusal at attend school, or issues with puberty: Not applicable ☐ None ☐

Middle / High School: 13-18 years. Describe any delays / problems: Not applicable ☐ None ☐

c. VISION: Glasses / contacts? No ☐ Yes ☐ (describe) _____

d. PHYSICAL HANDICAPS or PHYSICAL CHALLENGES: None ☐ Yes ☐ If yes, please describe:

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e. NUTRITION: Appetite is usually: Good ☐ Excessive ☐ Poor ☐ Variable ☐
Dental braces/appliances: None ☐ Yes ☐ (describe) _____
Do you have any concerns about the child's eating patterns or nutrition? No ☐ Yes ☐
If yes, please describe:

Is there a history of vomiting, binging, or excessive preoccupation with food? No ☐ Yes ☐
If yes, please describe:

f. MENSTRUATION: Not applicable ☐ Has menstruation begun? No ☐ Yes ☐
If yes, at what age did menstruation begin? _____
Has menstruation been: Regular ☐ Painful ☐
Do you think there are excessive signs of "PMS" (premenstrual syndrome)?: No ☐ Yes ☐
If yes, please describe:

g. SUBSTANCE USE: Not applicable ☐
Does child use, now or in the past, substances such as alcohol, marijuana or cocaine? No ☐ Yes ☐
If yes, please describe substances used, age of first use, and current usage patterns:

h. HEALTH AND MEDICATIONS:
Does child currently see a primary care doctor? No ☐ Yes ☐
Date of last visit? _____

Does the child have significant health concerns**?** No ☐ Yes ☐
If yes, please describe:

Does the child currently take medications, including for psychiatric reasons**?** No ☐ Yes ☐
If yes, please list medications with indications:

Please be aware that counselor encourages evaluation from medical doctor at onset of counseling to discuss behavioral and physical concerns.

7. **VIOLENCE/ABUSE:** Please describe any physical, verbal, emotional, or sexual abuse as the perpetrator, victim, or witness. Was the abuse reported to authorities? ☐ Not applicable.

_____

_____

8. **TRAUMA:** Please describe history and any concerns/issues of manmade, natural, or other trauma that may impact current treatment. ☐ Not applicable.

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_____

_____

9. **SEXUAL HISTORY:** Please describe history and any concerns/issues that may impact current treatment such as: age of first sexual encounter, sexual orientation, pregnancies, birth control, traumatic experiences, extra-marital affairs, at-risk behaviors, and sexual difficulties. ☐ Not applicable.

_____

_____

10. **SCHOOL INFORMATION: (*If in Day Care or Pre-school, please fill out as applicable)***

Name of School: _____ School Phone: _____

School Address: _____

Present Grade Level: _____ Special placement or classes? _____

Current Teacher: _____ Current Counselor: _____

Began school at what age? _____ Adjusted to school: Easily ☐ With difficulty ☐

Repeated a grade? No ☐ Yes ☐ If yes, list grade(s) repeated: _____

Best subjects: _____

Hardest subjects: _____

Most grades have been: A B C D F When, if ever, did work begin declining? _____

How does your child best learn? Reading ☐ Hearing ☐ Watching ☐ Hands-on ☐

Expulsions / Detentions / Suspensions? None ☐ Yes ☐ If yes, please describe:

Describe relationships with other students and teachers:

Additional comments about recent school behaviors?

11. **SPIRITUAL BACKGROUND:** Past and present religious affiliation, involvement in church, guiding spiritual principles:

Do you have any spiritual needs you need help addressing with your child?

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None ☐ Prayer ☐ Faith community ☐ Spiritual friend ☐ Spiritual reading ☐ Church attendance ☐ Other: _____

Would you like to discuss any of these spiritual issues with someone? No ☐ Yes ☐

12. OTHER FAMILY BACKGROUND INFORMATION:

a. RESIDENCES: Number of times the family has moved since the child was born: _____
Date of most recent move: _____ Number of school changes: _____

b. DISCIPLINE: What forms of discipline do you use when correcting your child? Indicate the form(s) that you think work best for your child and family:

Time outs ☐ Grounding ☐ Loss of toy/privilege ☐ Spanking ☐ Praise ☐
Contracts ☐ Rewards ☐ Other (describe):

Who is the main disciplinarian in your home? _____

Is there anything you want to write about the rules in your child's home(s) and how discipline occurs?
No ☐ Yes ☐ If yes, please describe:

16. LEISURE / HOBBIES / PLAY: What does your child enjoy doing in her / her free time? In what social activities, extracurricular activities, lessons or sports is he / she involved?

What kind of activities does your **FAMILY** enjoy together?

17. FINANCIAL: How would you describe your current financial status? Has child ever had a job? (Describe any financial concerns you have currently):

18. CHANGES: Any other changes such as friends moving, changes in custody, parents' work hours, parents' health, etc.? None ☐ Yes ☐ If yes, please describe:

19. MILITARY SERVICE: Is anyone in the immediate family currently serving in the Armed Forces? No ☐ Yes ☐

Has past service in the Armed Forces affected this family's history and relationships?
No ☐ Yes ☐ If yes, please describe service branch, dates, stations, and deployments as applicable:

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20. **FRIENDS / SOCIAL:** Do you have any concerns about your child's ability to choose and maintain friendships? No ☐ Yes ☐ If yes, please describe:

    Do you have a reason to believe child is being bullied by peers and/or bullying peers? No ☐ Yes ☐

21. **CULTURAL: Ethnicity / Race:** _____
    Are there any family cultural values or traditions the counselor should be aware of? (Foods, family organization, customs, etc.): No ☐ Yes ☐ If yes, please describe:

22. **PAST PSYCHIATRIC EXPERIENCES:** Please list names and dates of psychiatrists or hospitals, reason for visit, medications prescribed, and disposition:
    None ☐

23. **PAST COUNSELING EXPERIENCES:** Please list names and dates of therapists or clinics child has attended, topic of counseling, and disposition:
    None ☐

    TESTING: If psychological or educational testing has been done, summarize findings: None ☐

24. **STRENGTHS AND DIFFICULTIES:** What strengths or talents does your child have?

    What difficulties or limitations does your child have?

25. **OTHER INFORMATION:** Is there any other information about your child or family which you think would be helpful for the counselor to know? None ☐

Thank you for taking the time to complete this form. The information is greatly beneficial to your child's counselor.