Grace in Motion Counseling- Child New Client Information

TO BE COMPLETED BY **PARENT OR GUARDIAN**

*This confidential information is for use by counselor. Each child receiving services needs a separate form.

Date: _____

Child's Name: _____ Nickname/name child prefers: _____

Birth date: _____ Age: _____ Sex: _____ Race: _____ Child's primary phone: _____

Child's Home Mailing Address: _____City/Village: _____ State: _____ Zip: _____

Child's phone (if child has a cell): _____ Child's Email: _____

School child attends: _____ Grade: _____ Please circle: 504 ELP IEP

☐ Yes, I give permission for Grace in Motion to contact my child directly through child's phone and/or email.

MOTHER OF CHILD:

Name: _____ Birth date: _____ Age: _____ Sex: _____ Race: _____

Home Phone: _____ Cell phone: _____ Email: _____

Mailing Address: _____City / Village: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

Education (circle last completed): 4 5 6 7 8 9 10 11 12 College/Tech 1 2 3 Graduate 1 2 3

Degree Completed: _____ Other training (list type & years): _____

Military History: List branch of service and years_____Served in combat? _____

Current Marital Status: *Never Married Single Engaged Living with Married Widow Separated Divorced*

Spouse/Partner's Name:_____ Religious Affiliation/Church you attend: _____

FATHER OF CHILD:

Name: _____ Birth date: _____ Age: _____ Sex: _____ Race: _____

Home Phone: _____ Cell phone: _____ Email: _____

Mailing Address: _____City / Village: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

Education (circle last completed): 4 5 6 7 8 9 10 11 12 College/Tech 1 2 3 Graduate 1 2 3

Degree Completed: _____ Other training (list type & years): _____

Military History: List branch of service and years_____Served in combat? _____

Current Marital Status: *Never Married Single Engaged Living with Married Widow Separated Divorced*

Spouse/Partner's Name:_____ Religious Affiliation/Church you attend: _____

Marital status of **child's biological parents**: (Circle one)

Never Married Single Engaged Living with Married Widow Separated Divorced

If divorced, a copy of divorce decree & custody agreement signed by judge is required.

- Divorced Finalization Date: _____
- Describe custody arrangement: Which parent has primary physical custody? _____
  50/50 Other, please describe: _____
- Is custody resolved at this time? Yes or No If no, are you currently in court with this issue? Yes or No
- Is this child adopted? Y/N. **If yes, we <u>require</u> a copy of adoption papers.**

Note: If a stepparent, grandparent or other person is transporting child to appointments, a power of attorney and or written consent from either biological parent will be needed on file with GMC.

Siblings:	Age	Sex	Deceased	City they live in now
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Does anyone else live in your house? If so, who: _____

How would you rate your family's spiritual life? (10 great - 1 poor) _____ Why? _____

Check and comment about the following as they apply to you:

_____ Current/chronic medical conditions _____

_____ Recent weight changes: Lost _____ Gained _____ Cause? _____

_____ Serious illnesses/injuries/traumas _____

_____ Hospitalizations or surgeries _____

Do you have a prior diagnosis? _____

Physician: _____ Date of last exam:_____

Allergies: _____

List current medications & herbal supplements	Dosage	Prescriber?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has child had previous counseling? Yes No If yes, with who and when? _____

_____

Describe the concerns that brings your child to counseling: _____

_____

Name strengths and goals of child:_____

_____

Does child have friendships or a support system? Yes No Please describe: _____

_____

Please describe your family psychiatric history, please list any mental illness: _____

_____

Please describe any family legal history: _____

Do you have any problems with sleep? (please circle) Yes No

Sleeping too little Sleep too much Can't fall asleep Can't stay asleep

Any difficulty with appetite or eating habits? (please circle) Yes No

Eating less Eating more Binging Purging Not eating

Have you ever had a head injury? (please circle) Yes No When and what happened? _____

_____

What else would you like us to know that we may not have asked? _____

_____

Have child rate their distress level for ALL of the following:

6	5	4	3	2	1	0
Maximum	**Very Considerable Distress**	**Considerable**	**Moderate**	**Little**	**Very Little**	**No Distress**

Please explain:

_____ Depressed mood, loss of hope _____

_____ Suicidal thought _____

_____ Suicidal actions _____

_____ Anxiety, worry, stress _____

_____ Panic Attacks _____

_____ Sleep problems _____

_____ Eating habits/ concerns _____

_____ Withdrawn behavior _____

_____ Physical health problems _____

_____ Head trauma _____

_____ Domestic violence _____

_____ Parent/child conflict _____

_____ Addiction to drugs or alcohol _____

_____ Addiction to pornography _____

_____ Computer/gaming addiction _____

_____ Alcohol/other drugs (family) _____

_____ Emotional abuse _____

_____ Anger _____

_____ Low-self esteem _____

_____ Sexual abuse _____

_____ Brother/sister problems _____

_____ Blended family issues _____

_____ Guilt _____

_____ Sexual identity issues _____

_____ Sexually active _____

_____ Experience bullying in school _____

_____ Grief _____

_____ Religious Concerns _____

_____ Fear _____

_____ Racing thoughts _____

_____ Mood Swings _____

_____ Trauma _____