Abundant Life Counseling St. Louis LLC

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Client Information

Date: ____________________

CHILD'S NAME: ____NICKNAME:______________________

Date of Birth: _____/______/_____ Gender: ☐ Female ☐ Male ☐ Transgender

Address: ____ City _________________ State_______ Zip__________

Child's School: ____ Grade: _______________

PARENT'S NAME: ____

Preferred Phone number: ____ ☐Home ☐Cell ☐ Work

Email address: ____

Address: (☐ Same as above) ____

Relation to Child: ☐ Mother ☐Father ☐Grandma ☐Grandpa ☐Aunt ☐Uncle ☐Other:_______

Date of Birth: _____/______/_____ Occupation: ____

☐ Unemployed ☐ Full-Time Parent ☐Employed Part-Time ☐Employed Full-Time

Highest Education Level: ____

Military Service Branch: ________________ Dates of Service: ____________ Highest Rank: _________

Race: ☐ Caucasian ☐ African American ☐Hispanic ☐ Asian American ☐ Other: ________________

Religion/Church Affiliation: ☐ Jewish ☐ Catholic ☐ Protestant ☐ None ☐Other: _______________

Primary Place of Worship/Church Home:____

PARENT'S NAME: ____

Preferred Phone number: ____ ☐Home ☐Cell ☐ Work

Email address: ____

Address: (☐ Same as above) ____

Relation to Child: ☐ Mother ☐Father ☐Grandma ☐Grandpa ☐Aunt ☐Uncle ☐Other:_______

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Religion/Church Affiliation: ☐ Jewish ☐ Catholic ☐ Protestant ☐ None ☐Other: ______________

Primary Place of Worship/Church Home:____

Parent Marital Status:

☐ Married (__________ mos/years) ☐ Living Together Without Marriage (__________ mos/years)

☐ Never Married ☐ Widowed (__________ mos/years) ☐ Engaged

☐ Divorced/Separated (__________ mos/years)

Legal Custody: ☐ Mother/Father ☐ Mother ☐ Father ☐ Other: _______________________

Physical Custody: ☐ Mother/Father ☐ Mother ☐ Father ☐ Other: _______________________

Parenting Plan: ☐ N/A ____

OTHERS IN THE HOME:

Name	Age	Relation to Child
______________________________________	__________	____________________________________
______________________________________	__________	____________________________________
______________________________________	__________	____________________________________

____________________________________ _________ ___________________________________

TOTAL NUMBER IN HOUSEHOLD: ________

Primary Physician: ____ Phone: _____________________

Date of last physical exam: ____

Psychiatrist: ____ Phone: _____________________

IN CASE OF EMERGENCY CONTACT:

Name: ____ Preferred Number: ____________________

How did you hear about Abundant Life Counseling St. Louis and/or Julie Williamson, LPC, RPT?

____

May I send that person/organization a thank-you note for referring you? ☐ Yes ☐No

What are your current concerns? ____

____

Why have you sought treatment for your child now?_____________________________________

____

What are your expectations for treatment?____

____

Have you previously sought counseling for these and/or other concerns? ☐ Yes ☐No

Therapist__________________________ Profession ______________ Dates: _____________

Therapist__________________________ Profession ______________ Dates: _____________

How satisfactory was your experience(s)? ____

____

Is your child presently working with any other Counselor or Psychologist? ☐ Yes ☐No

For what reason? ______________________ Therapist: ______________________________

Are you or your child involved in any other counseling or support group?
☐ No
☐ Yes – Group Name: ___________________________________ Leader: ___________________________

Does your child currently have thoughts of harming him/herself or someone else? ☐ Yes ☐No

DEVELOPMENTAL HISTORY:
Pregnancy: Planned? ☐ Yes ☐No Complications: ____
Full Term? ☐ Yes ☐No
While pregnant, use of: ☐ Drugs ☐Alcohol ☐ Tobacco ☐Medications
If yes, please describe:
____

____
Labor: ☐ Normal ☐Induced ☐ C-Section Birthplace/City: __________________________

Birth: Complications: ____

☐ Required oxygen at birth ☐ Jaundice ☐ Colic ☐Allergies ☐ Poor sucking ability ☐Poor weight gain

Milestones: Check any delays in the following milestones before age 7:

☐ Rolling over ☐ Speech ☐ Sitting ☐Crawling ☐ Walking ☐Toileting ☐ Running ☐ Feeding

Please explain any delays: ____

____

Early Childhood Problems: Check any difficulties with the following before age 7:

☐ Became easily frustrated ☐ Preferred structured routine ☐ Complained of physical pains
☐ Tried to control situations ☐ Nightmares ☐ Unusual fears ☐ Difficulty with impulse control
☐ Emotional sensitivity ☐ Difficulty following instructions or rules ☐ Bedwetting ☐ Aggression
☐ Needed to change activities frequently or do something that someone else was doing
☐ Difficulty forming relationships, making friends, or being accepted by peers
☐ Difficulty with organizational skills ☐Immature social interests ☐ Need immediate gratification
☐ Difficulty taking turns with others ☐ Difficulty making friends
☐ Other: ____

MENTAL HEALTH HISTORY: Has your child or a child's family member ever experienced or been diagnosed with the following?

	Child	Family Member	This Person's Relation to Child?
Depression	☐ Yes ☐No	☐ Yes ☐No	
Anxiety	☐ Yes ☐No	☐ Yes ☐No	
Suicidal Thoughts and/or Actions	☐ Yes ☐No	☐ Yes ☐No	
Bipolar Disorder	☐ Yes ☐No	☐ Yes ☐No	
Alzheimer's	☐ Yes ☐No	☐ Yes ☐No	
Paranoia	☐ Yes ☐No	☐ Yes ☐No	
Learning Difficulties	☐ Yes ☐No	☐ Yes ☐No	
ADHD	☐ Yes ☐No	☐ Yes ☐No	
Hallucinations/Delusions	☐ Yes ☐No	☐ Yes ☐No	
Eating Problems	☐ Yes ☐No	☐ Yes ☐No	
Behavior Problems	☐ Yes ☐No	☐ Yes ☐No	
Sleep Problems	☐ Yes ☐No	☐ Yes ☐No	
Alcohol Addiction	☐ Yes ☐No	☐ Yes ☐No	
Drug Addiction	☐ Yes ☐No	☐ Yes ☐No	
Other Addictions	☐ Yes ☐No	☐ Yes ☐No	
Physical Abuse	☐ Yes ☐No	☐ Yes ☐No	
Sexual Abuse	☐ Yes ☐No	☐ Yes ☐No	
Self-Harming Behavior	☐ Yes ☐No	☐ Yes ☐No	
Witness or Victim of Domestic Violence	☐ Yes ☐No	☐ Yes ☐No	

Any other mental health concerns you would like to mention? ____

____

Please describe any sleep disturbances your child might be experiencing: ___________________________

____

Has your child ever been hospitalized for mental illness or substance abuse? ☐ Yes ☐No

If yes, for what reason? ____

Dates of Treatment: ____

Treatment Center/Hospital Name: ____

Did your child continue with outpatient counseling? ☐ Yes ☐No

Name of Counselor: ____

Has your child previously met with a psychiatrist? ☐ Yes (please complete table below) ☐No

Psychiatrist's Name	Diagnoses Given	Dates of Treatment

SUBSTANCE ABUSE/DEPENDENCE:
Have you or your child ever used the following substances:

	Current	Substance	Date of Last Use:
Depressants (e.g. alcohol)	☐ Yes ☐No		
Stimulants (e.g. cocaine)	☐ Yes ☐No		
Narcotics (e.g. Demerol)	☐ Yes ☐No		
Hallucinogens (e.g. PCP)	☐ Yes ☐No		
Cannabinoids (e.g. marijuana)	☐ Yes ☐No		
Other Substances:	☐ Yes ☐No		

CURRENT ENVIRONMENTAL STRESSORS:

Recent or Significant Death	☐ Yes ☐No	Relation(s) to Self: Date:
Significant Moves:	☐ Yes ☐No	Date(s): Location(s):
Child Medical Problems:	☐ Yes ☐No	Please Explain:
Family Medical Problems:	☐ Yes ☐No	Please Explain:

Financial Problems:	☐ Yes ☐No	Please Explain:
Safety of Yourself and/or Others:	☐ Yes ☐No	Please Explain:

Other Stressors: ____

PHYSICAL HEALTH & MEDICAL HISTORY:

Child's Physical Health Status: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list your child's previous medical doctors, diagnoses, and dates of treatment:

____

____

____

____

Your child's current medications: ☐ N/A ☐ Yes:

____Dose___________________________

____Dose___________________________

____Dose___________________________

Has your child ever experienced the following:

Head Injury? ☐ No ☐Yes (please explain with dates: ____________________________)

Concussion? ☐ No ☐Yes (please explain with dates: ____________________________)

Seizure? ☐ No ☐Yes (please explain with dates: ________________________________)

Serious Accident? ☐ No ☐Yes (please explain with dates: _________________________)

Major Surgery? ☐ No ☐Yes (please explain with dates: ___________________________)

Medical Hospitalizations? ☐ No ☐Yes (please explain with dates: __________________)

Medical Problems (Check all that apply for your child):

☐ AIDS/HIV+	☐Blood Pressure	☐Gout	☐Irritable Bowel	☐Osteoporosis
☐ Allergies	☐ Cirrhosis	☐ Heart Attack	☐Kidney Disease	☐Peptic Ulcer
☐ Alzheimer's	☐ Cancer	☐Hepatitis	☐ Lyme Disease	☐ Pleurisy
☐Arthritis	☐ Crohn's/Colitis	☐ Heart Disease	☐Lupus	☐Parkinson's
☐Angina	☐ Dermatitis	☐ Herpes	☐Meningitis	☐ Sinusitis
☐Asthma	☐ Diabetes	☐ Headaches	☐ Migraine	☐Stroke
☐ Atrial Fibrillation	☐ Emphysema	☐ Hyperthyroid	☐ Multiple Sclerosis	☐ Tuberculosis
☐Bronchitis	☐ Epilepsy	☐ Hypothyroid	☐ Obesity	☐Urinary Tract

☐ Other Medical Problems (specify):____

LEGAL HISTORY

Present Charges for Parent and/or Child: ☐ Yes ☐ No

☐ Mother (please list charge and date: ______________________________________)

☐ Father (please list charge and date: ______________________________________)

☐ Child (please list charge and date: ______________________________________)

Past Charges for Parent and/or Child: ☐ Yes ☐ No

☐ Mother (please list charge and date: ______________________________________)

☐ Father (please list charge and date: ______________________________________)

☐ Child (please list charge and date: ______________________________________)

Any other current legal concerns? ____

____

____

Is there any other information you would like to share? ______________________________

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