DOOR of HOPE
COUNSELING

BACKGROUND: CHILD/ADOLESCENT

Please answer all information as completely as possible. If applicable, both parents should complete together. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. Your child's counselor will discuss your responses with you after he/she has reviewed the form.

*Child's Name:*_____ *Date of First Visit:* _____
Last First MI

Completed by: _____ *Relationship to Child:* _____

Home Phone: _____ (***May call?*** Yes No ***May Leave Message?*** Yes No)

Work Phone: _____ (***May call?*** Yes No ***May Leave Message?*** Yes No)

Cell Phone: _____ (***May call?*** Yes No ***May Leave Message?*** Yes No)

Best Time and Place to call: _____

Child's Address: _____
Street City State Zip

Child's Gender: _____ *Date of Birth* ___/___/___ *Age* ____

Child's Ethnicity:
___African American ___Bi-racial ___Hispanic/Latin
___Asian ___Caucasian ___Native American Other _____

Child's Legal Guardian (Managing Conservator)*:* _____
(If the child is not living with both natural parents, both adoptive parents, or only living parent, the state of Texas requires a copy divorce decree be part of the child's clinical file. Please bring a copy to your Door of Hope Counselor.

Is your child currently on probation? Yes No *School child attends:* _____

*School District*_____

*Grade Level (*now): _____ *Has your child ever been retained? Yes No If yes, what grade?* _____

*Is your child receiving special education or other services? Yes No (explain)*_____

History of learning, emotional, behavioral problems: Yes No

(If yes, please explain) _____

_____

Is your child presently receiving counseling elsewhere? Yes No
(If yes, do not complete this form until you have talked with your counselor)

Located on the campus of Freedom Fellowship Church
410 Oak Run Point, New Braunfels, TX 78132
Phone: 830-632-5039

Has your child ever seen a mental health professional (psychiatrist, psychologist, or a counselor)? Yes No

(If so, we will need your permission in order to communicate with that individual or agency)

Previous Mental Health Professional/Agency: _____
Name Address

Phone: _____ Dates of Service: _____(beginning - ending)
Has your child been hospitalized for mental health concerns? Yes No

If yes: When _____ Where_____

Are you seeking services because your child is a victim of a crime? Yes No

Did it result in legal action? Yes No *(If Yes, explain)*_____

INFORMATION ON CHILD'S MOTHER

Mother's Name: _____
Last First MI
I am: __ *biological mother* ___*stepmother* ___*adoptive mother* *Other*_____

Address: _____
Street City State Zip

If different form above:
Home Phone: _____ *Work Phone:* _____
(May call: Yes No Leave Message: Yes No) (May call: Yes No Leave Message: Yes No)

Cell Phone: _____
(May call: Yes No Leave Message: Yes No)

Date of Birth: _____ *Occupation:* _____
Employer: _____ *How Long:* _____

Education Level of Mother:
___8th grade or below ___High School ___GED
___Trade School/Some College ___Undergraduate Degree ___Graduate Degree

Current living arrangements:
___Family of origin ___Single ___Spouse/Partner ___Roommate ___Other____

Marital Status (indicate all that apply and duration of each, ex. 1965-1985):
___Never married _____Currently married _____Divorced _____Widowed

Marital History
___Number of Marriages ___Number of Divorces

INFORMATION ON CHILD'S FATHER

Father's Name: _____
Last *First* *M.*
I am __ *biological father* ___*stepfather* ___*adoptive father* *other* _____

Address: _____
Street City State Zip

If different form above:
Home Phone: _____ *Work Phone:*____ _____
(May call: Yes No Leave Message: Yes No) (May call: Yes No Leave Message: Yes No)
Cell Phone: _____
(May call: Yes No Leave Message: Yes No)

Date of Birth: _____ *Occupation:* _____
Employer: _____ *How long:* _____

Education Level of Father
___8th grade or below ___High School ___GED
___Trade School/Some College ___Undergraduate Degree ___Graduate Degree

Current living arrangements:
___Family of origin ___Single ___Spouse/Partner ___Roommate ___Other_____

Marital Status (indicate all that apply and duration of each, ex. 1965-1985):
___Never married ___Currently married ___Divorced ___Widowed

Marital History
___Number of Marriages ___Number of Divorces

GENERAL INFORMATION

List by Household your child's current family, beginning with the oldest member and include the child:

Primary Household (anyone who currently lives with child)

How long in this current living situation: _____

Name	Age	Gender	Relationship to child (include step, half, etc.)

Child lives in: ___House ___Apartment ___Duplex ___Other_____

Second Household (non-custodial or extended family - if applicable)

Name	Age	Gender	Relationship to child (include step, half, etc.)

Currently involved in a custody dispute: No Yes (If yes, explain) _____

_____

If divorced, circle the number which best describes your relationship with your ex-spouse.

Hostile		Neutral		Friendly
1	2	3	4	5

How often does client see non-custodial parent? _____

RELIGION / SPIRITUALITY

Does religious faith play an important part in the life of the child's family? Yes No

If so, what faith community do you belong/attend: _____

What religious/spiritual activities does your family participate in? For example, daily prayer, reading of scripture, etc.

_____

_____

_____

_____

_____

_____

_____

CHILD'S DEVELOPMENTAL HISTORY

Did your child meet typical developmental milestones? Yes No

If no, which milestones were not met at the typical time? And has your child now met those milestones?

_____

_____

_____

_____

_____

_____

CHILD'S HEALTH

Date of LAST complete physical: _____

Physical Disability: Yes No (If yes, explain) _____

Chronic Illness: Yes No (If yes, explain) _____

Terminal Illness: Yes No (If yes, explain) _____

HISTORY OF TRAUMA and/or STRESSORS

Please answer these questions regarding the child's life:

1. Did a parent or other adult in the household **often** …swear at the child, insult the child, put your down, or humiliate the child? **Or,** act in a way that made the child afraid that she/he might be physically hurt?

   Yes No If yes, at what age did the child experience this: _____

2. Did a parent or other adult in the household **often** …push, grab, slap, or throw something at the child? **Or,** ever hit the child so hard that marks or injured resulted?

   Yes No If yes, at what age did the child experience this: _____

3. Did an adult or person at least 5 years older than the child **ever**…touch or fondle or touch their body in a sexual way? **Or,** Try to or actually have oral, anal, or vaginal sex with the child?

   Yes No If yes, at what age did the child experience this: _____

4. Could the child **often** feel that …no one in his/her family loved or thought he/she were important or special? **Or,** the family didn't look out for each other, feel close to each other, or support each other?

   Yes No If yes, at what age did the child experience this: _____

5. Did the child **often** feel that …did not have enough to eat, had to wear dirty clothes, and had no one to protect him/her? **Or,** the child's parents were too drunk or high to take care of the child or take the child to the doctor if needed?

   Yes No If yes, at what age did the child experience this: _____

6. Were the child's parents **ever** separated or divorced?

   Yes No If yes, at what age did the child experience this: _____

7. Was the child's mother or stepmother: **Often** pushed, grabbed, slapped, or had something thrown at her? **Or, sometimes or often** kicked, bitten, hit with a fist, or hit with something hard? **Or ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?

   Yes No If yes, at what age did the child experience this: _____

8. Did the child live with anyone who was a problem drinker or alcoholic or who used street drugs?

   Yes No If yes, at what age did the child experience this: _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?

   Yes No If yes, at what age did the child experience this: _____

10. Did a household member go to prison?

    Yes No If yes, at what age did the child experience this: _____

*** OTHER TRAUMA/STRESSORS RELATED TO THE CHILD ***

(For each of the following items that apply, write in your child's approximate age at the time it occurred):

___Chronic illness of family member ___Death of significant person

___Child separated from parent (how long and when) _____

___Death of a pet ___Difficult medical treatments ___Natural Disaster

Check the following items for a diagnosis or medication that your child is now receiving or has received:

Diagnosis	**Current** (list dates)	**Past** (list dates)	**Physician's Name**	**Name of medication**	**Dosage**
Depression	_____	_____	_____	_____	_____
ADHD	_____	_____	_____	_____	_____
ADD	_____	_____	_____	_____	_____
Conduct Disorder	_____	_____	_____	_____	_____
Anxiety/ Nervousness	_____	_____	_____	_____	_____
Bipolar	_____	_____	_____	_____	_____
Schizophrenia	_____	_____	_____	_____	_____
Oppositional Defiant Disorder	_____	_____	_____	_____	_____
Mood/Anger	_____	_____	_____	_____	_____
Tics	_____	_____	_____	_____	_____
Insomnia/ Sleeplessness	_____	_____	_____	_____	_____
Obsessive/ Compulsive	_____	_____	_____	_____	_____
Seizures	_____	_____	_____	_____	_____
Post-Traumatic Stress Disorder	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

(If you do not know the name and dosage of current medication, please bring the medication to your next session)

What other medication is your child currently taking?

Medication	Dosage	Taken for what reason?
_____	_____	_____
_____	_____	_____
_____	_____	_____

* CURRENT CONCERNS *

Circle the item that you see as the most significant issue for your child. Underline any additional concerns.

Problems Related to Abuse

Current or past physical abuse
Current or past sexual abuse
Current or past emotional abuse
Current or past neglect
History of abandonment
Suspected sexual abuse
History of family domestic violence

Academic/School Problems

Learning difficulties
Problems with peers
Problems with teachers

Mood-related Concerns

Disturbing memories
Difficulty going to sleep/staying asleep
Nightmares/night terrors
Suicidal ideation
Sadness
Depression
Feelings of guilt and shame
Excessive worrying

Family Relationship Concerns

Difficulty adjusting to family changes
Discipline concerns
Parent-child relationship problems
Sibling concerns
Divorce/Separation
Religious/Spiritual Concerns

Rule-Breaking/Behavior Problems

Aggression toward others
Drug/alcohol use
Truancy
Gang involvement
Running away
Stealing
Intentionally hurting animals
Fire-setting
Other unusual behaviors (please specify) _____

Other Behavioral Concerns

Gender identity concerns
Inappropriate sexual behavior
Overeating/refusal to eat
Bedwetting or soiling
Hyperactive/Inattentive

Remember to circle the most significant issue.

When did you first become concerned about the main/most significant issue?_____

How have you attempted before now to deal with this issue? _____

_____

_____

_____

_____

_____

_____

_____

_____

History of your child having learning, emotional, behavioral problems: Yes No

(If yes, please explain) _____

School Problems (check all that apply):

_____Academic problems _____Discipline problems _____Social Problems ___Other _____

History of health/physical problems includes: (check all that apply):

_____Asthma
_____Bedwetting
_____Neurological problems/exam
_____Severe PMS
_____Heart Palpitations
_____Shortness of breath without exertion
_____Sleep problems
_____Surgeries
_____Nervous stomach
_____Dizziness
_____Severe Headaches
_____Chest pain
_____Serious overeating/under-eating
_____Major accident
_____Chronic Diarrhea
_____Other_____

HOME ATMOSPHERE

What do you enjoy most about this child? _____

What do you find most difficult about this child? _____

Anything else you think we need to know? _____

What is the one thing we need to know to help your child today? _____

ANY OTHER INFORMATION YOU THINK WOULD BE HELFPUL

Thank you.