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FAMILY THERAPY

AUTHORIZATION TO TREAT MINOR CHILD

I/We, _____, give my permission to
[Name of Parent(s) or Guardian(s)]

_____ to engage my son/daughter
[Therapist]

_____ for treatment or counseling,
[Name of Minor Child]

with or without me/us being present in the same session. I/we understand that therapists must assert confidential privilege – the right to withhold disclosure of private, therapy related information about my/our child. However, in the interest of developing a trust relationship between the therapist and my/our child, I/we give the therapist permission to reveal or withhold information that in the therapist's clinical judgment is necessary to best help and protect my/our child.

The only exception to this discretion would be in the case of _____

_____

_____

_____	_____	_____
Parent / Guardian Printed Name	Parent / Guardian Signature	Date
_____	_____	_____
Parent / Guardian Printed Name	Parent / Guardian Signature	Date
_____	_____	_____
Therapist / Witness Printed Name	Therapist / Witness Signature	Date

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CHILD-ADOLESCENT HISTORY

Name: _____ Age_____

Who will be present at the initial interview?

_____

PRESENTING COMPLAINT
Main problem(s) your child is having at this time. _____

_____

What made you decide to bring your child for treatment at this time? _____

CURRENT FUNCTIONING
Has your child experienced any of the following sleep problems recently?

Difficulty falling asleep	Waking during the night
Waking early	Nightmares/night terrors
Fears at bedtime	

Weight change or problems with appetite recently?

Decreased appetite:	Yes	No	
Increased appetite:	Yes	No	
Lost weight?	Yes	No	Lbs.:_____
Gained weight?	Yes	No	Lbs.:_____

Unusual eating habits (describe):
_____
_____

Has your child ever:

Talked about harming self or others?	Yes	No
Had a specific plan for harming self or others?	Yes	No
Made an attempt to harm self or others?	Yes	No
Is this a problem right now (describe):	Yes	No

_____
_____

Please identify any of the following behaviors that would be true about your child:

Flexible	Outgoing	Thumb sucking
Daydreams	Cooperative	Nightmares
Temper tantrums	Excessive fears	Hardworking
Grasps ideas quickly	Engages in stealing	Avoids homework
Uncooperative	Lacks self-control	Lacks motivation
Low frustration tolerance	Soiling	Difficulty making decisions
Rocking	Bed wetting	Difficult routine changes
Creative	Unusually aggressive	Nail biting
Overactive	Gentle/Sensitive	Needs constant approval/reassurance

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Unusual sexual behaviors	Pessimistic thinking	Consistently short attention span
Easily influenced by others	Underactive	Self-confident
Difficulty telling time	Frequently tells lies	Difficulty making/keeping friends
Difficulty with organization	Frequent, sudden mood changes	Usually shy or withdrawn
Difficulty using numbers	Changes in sleep patterns	Doesn't seem to understand questions or directions
Other:_____		

Please describe your child's strengths:

_____

_____

Please list your child's involvement in the following activities:

Sports: _____

Creative Arts (music, dance, art):_____

Church:_____

Other Interests:_____

CHILD SOCIAL/FAMILY HISTORY

1. List all individuals currently living in your household:

Name:_____ Age:_____ Relationship _____

Name:_____ Age:_____ Relationship _____

Name:_____ Age:_____ Relationship _____

Name:_____ Age:_____ Relationship _____

Name:_____ Age:_____ Relationship _____

Name:_____ Age:_____ Relationship _____

2. List other immediate family members not currently living in your household:

Name:_____ Age:_____ Relationship _____

Name:_____ Age:_____ Relationship _____

Name:_____ Age:_____ Relationship _____

Name:_____ Age:_____ Relationship _____

3. List any other significant adults in your child's life:

Name:_____ Age:_____ Relationship _____

Name:_____ Age:_____ Relationship _____

Name:_____ Age:_____ Relationship _____

Name:_____ Age:_____ Relationship _____

4. Marital status of child's biological parents:

Never married			
Married	Yes	No	Date(s):_____
Separated	Yes	No	Date(s):_____ _____

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Divorced Yes No Date(s):_____ _____
Remarried (mother) Yes No Date(s):_____ _____
Remarried (father) Yes No Date(s):_____ _____
Additional Information:_____
_____
_____

5. Occupational status of the child's parents/step-parents:
Mother: _____
Stepmother: _____
Father: _____
Stepfather: _____
Legal Guardian(s): _____

6. If divorced, please answer the following:
Who has legal custody? Joint Custody Mother Only Father Only
Who has physical custody? Joint Custody Mother Only Father Only
Please describe current visitation schedule including summer arrangements:
_____
_____
_____

Any current court action regarding custody or visitation? Yes No
If yes, please describe:
_____
_____
_____

7. My child has experienced significant loss(es): Yes No
Please describe:
_____

8. Number of times your household has moved during child's lifetime:_____

9. Please list significant family stressors that occurred during the past two years including marital dissatisfaction or marital instability:
_____
_____
_____

10. What type of discipline methods does your family use? _____
_____

Are these discipline methods effective? Please describe: _____
_____

11. How does your child get along with his/her siblings most of the time?
Positive Interaction Negative Interaction Little or Not Interaction
Please describe:
_____
_____

12. What support systems does your family have? (e.g., extended family, church friends, neighbors, etc.)
Please describe:
_____
_____
_____

13. What kind of activities does your family enjoy doing together? Please describe:
_____
_____

DEVELOPMENTAL HISTORY

1. Number of pregnancies: _____ This child is #_____ of _____ children in the family.
2. Was this a planned pregnancy? Yes No
3. Is this child adopted? Yes No Date of adoption: _____
4. Did any of the following difficulties occur during pregnancy?
   - Hospitalization Bed rest Blood loss Toxemia
   - Smoking Alcohol use Drug use Gestational diabetes
   - Other illnesses:_____
5. Was your child born:
   - 2+ weeks early On time More than two weeks late
6. Labor and Delivery information:
   - Spontaneous Induced
   - Length of labor: _____
   - Type of delivery: Normal Caesarean Other: _____
   - Birth Weight: _____
   - Apgar score (if known): _____
7. Did your child experience any difficulties during the labor process? Yes No
8. Did your child require any special care immediately following delivery, such as:
   - Oxygen Diagnosis of birth defect
   - Warming/lights Intensive care
   - Other:_____
9. During the **first year of life**, did any of the following occur:
   - Excessive crying Difficulty calming Colic
   - Difficulty sleeping Restless/squirmy Reacting poorly to changes
   - Difficulty feeding Other:_____
   - Sensitivity to noise, light, texture, clothing
10. Please indicate the age when your child:
    - Began crawling:_____
    - Began walking unassisted:_____
    - Spoke first words:_____
    - Began speaking in short sentences:_____
    - Was toilet trained:_____
11. As a **toddler**, did your child experience any of the following:
    - Excessive temper tantrums Difficulty with changes
    - Nightmares Sensitivity to noise, light, texture, clothing
    - Over activity Being withdrawn

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Excessive difficulty with separation Other:_____

MEDICAL HISTORY

(Please include below an incidence of allergy, head injury, hospitalization, seizures, surgery, or other significant health problems)

What is the date of your child's last complete physical? ____/_____
What is the date of your child's last eye exam? ____/_____
Does your child wear glasses/contacts? Yes No
What is the date of your child's last hearing screening? ____/_____
Does your child have allergies? Yes No
Medication _____
Taken How Long? _____
Allergy History:_____
Date Diagnosed Type of Allergy_____

Past Medical History:

Does your child have a history of head injury? Yes No
If yes, please explain:_____

Does your child have a history of repeated strep infections? Yes No
If yes, please explain:_____

Has your daughter started her menstrual cycle? Yes No
If yes, when: _____

PSYCHOLOGICAL/PSYCHIATRIC HISTORY

Previous Inpatient Mental Health Services:

Where? _____
When? _____
For What? _____
For How Long?_____
What type of treatment?_____
Was it helpful?_____

Previous Outpatient Mental Health Services:

Where? _____
When? _____
For What? _____
For How Long?_____
What type of treatment?_____ _____
Was it helpful?_____

ABUSE HISTORY:

Has your child been the victim of any actual or suspected child abuse (e.g., physical, sexual, or emotional abuse)?
Where? _____
When? _____
By Whom? _____
Was it reported?_____

Has your child ever abused others?
Where? _____
When? _____
By Whom? _____
Was it reported?_____

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Is there a history of abuse among extended family? If yes, please describe below:_____
_____
_____

ALCOHOL/SUBSTANCE ABUSE HISTORY:
What? / Frequency of Use?
_____
_____

FAMILY MEDICAL HISTORY
(Please list below serious illnesses that siblings, parents, grandparents/other close relatives have experienced.)
Severe Medical Problems:
Who? _____
What?_____
When?_____

Alcohol/Substance Abuse:
Who? _____
What?_____
When?_____

Psychiatric Problems:
Who? _____
What?_____
When?_____

Attention Deficit Disorder, Developmental Disorder, Learning Disabilities:
Who? _____
What?_____
When?_____

EDUCATIONAL HISTORY
Has your child ever been retained (held back) in school? Yes No
What grade(s)?_____
How many school moves or changes have your child experienced?_____
Please describe:_____
_____

Does your child have specific difficulties with learning in the school setting? Yes No
If yes, briefly describe any learning concerns or problems _____
_____
_____

Has your child ever been evaluated for problems at school by any of the following (please check if applicable and list age or grades when completed):
School psychologist evaluation _____
School social worker evaluation _____
Speech/language evaluation _____
Hearing assessments _____
Physical or occupational therapist evaluation _____
Specific academic assessments _____
Other _____

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Has your child received Special Education services? Yes No

If Yes, please circle which grades involved Special Education:

K 1 2 3 4 5 6 7 8 9 10 11 12

What specific diagnosis was established?

Emotionally Impaired
Trainable Mentally Impaired
Speech and Language Impaired
Autistically Impaired
Preprimary Impaired
Physically & Otherwise Health Impaired
(i.e. Attention Deficit/Hyperactivity Disorder,
Sensory Integration Issues, & Physical Impairment)
Educable Mentally Impaired
Specific Learning Disability
Hearing Impaired
Severely Multiply Impaired
Visually Impaired

When was the last Individualized Educational Planning Committee meeting?

_____ Did you attend? Yes No

If your child has been labeled, in what type of program is the child placed? _____

_____

How well has your child done in terms of grades over time?

Extremely bad Poor Average Above Average Exceptional

What are your child's current grades?

Math_____ English_____ Social Studies_____

History_____ Science_____ Foreign Language_____

Other (list subject & grade)_____

Has your child had any significant difficulties with discipline in school? Yes No

If Yes, please explain: _____

_____

Has your child been suspended or expelled? Yes No

If yes, please explain:_____

_____

_____

How does your child get along with authority figures in school?

Poor Average Above Average

Does your child have any difficulty attending or completing tasks at school? Yes No

If Yes, please explain: _____

_____

Does your child Like or Dislike school?

Comments:_____

_____

Does your child have any difficulty with attendance or tardiness? Yes No

If Yes, please explain: _____

_____

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Does your child have any additional earlier history regarding acting out (e.g., violation of other specific school rules)?
Yes No
If Yes, please explain: _____
_____

RELATIONSHIP HISTORY

Please rate your child on the following skills/behaviors:

1. Interacts cooperatively with siblings:	mostly	sometimes	rarely
2. Can resolve arguments with others:	mostly	sometimes	rarely
3. Can make friends/initiate social contact:	good	fair	poor
4. Can maintain friendships:	good	fair	poor
5. Chooses appropriate/positive friends:	mostly	sometimes	rarely
6. Prefers children who are:	younger	same age	older
7. Prefers to play alone:	mostly	sometimes	rarely
8. Can entertain him/herself independently:	good	fair	poor

LEGAL HISTORY

Has your child ever been arrested? Yes No
If yes, what was the charge? _____
Has your child ever been on probation? Yes No
Has your child even been in jail? Yes No
If yes, when and how long?_____

RELIGIOUS HISTORY

Does your family have a religious affiliation? Yes No
If yes, please describe:_____

PARENT GOALS

What positive changes would you like to see occur for your child and/or family by coming to the Christian Counseling Center?
_____
_____
_____

_____ _____
Parent (Guardian) Signature Date

_____ _____
Parent (Guardian) Signature Date