Creason Counseling
5511 E. 82nd Street, Suite K
Indianapolis, IN 46250
317-721-9585

This form is to be filled out by the child's parent and /or legal guardian.

Today's Date _____

Person completing form: _____ Relationship to child: _____

Child's Information:

First Name:	Last Name:		Age:
Nickname:	Sex: M F	Adopted: Y N	Birth date:
Grade:	School:	Teacher/School Counselor:	

Parents:

Name: _____ Sex: Male Female
Last *First* *Middle*

Relationship to child: _____

Home Phone: _____ Okay to call this number? _____ Leave message? _____

Work Phone: _____ Okay to call this number? _____ Leave message? _____

Cell Phone: _____ Okay to call this number? _____ Leave message? _____

Home Address: _____
Street City State Zip

Email Address: _____ Occupation: _____

Birth date: _____/_____/_____ Are you married? _____ Name of spouse _____

Name: _____ Sex: Male Female
Last *First* *Middle*

Relationship to child: _____

Home Phone: _____ Okay to call this number? _____ Leave message? _____

Work Phone: _____ Okay to call this number? _____ Leave message? _____

Cell Phone: _____ Okay to call this number? _____ Leave message? _____

Home Address: _____
Street City State Zip

Email Address: _____ Occupation: _____

Birth date: _____/_____/_____ Are you married? _____ Name of spouse _____

Have you ever sought counseling for your child before? Yes No

If yes, name of professional: _____ Duration of counseling:_____

If there has been psychological testing completed for this child please provide a copy of the reports with this form.

How were you referred to this center?_____

List all persons living in the home:

Name	Age	Sex	Relationship

List other children not living in the home:

Name	Age	Sex	Relationship

Child's Primary Physician:

Doctor's Name: _____ Type of Doctor: _____

Office Phone: _____ Fax: _____

Address: _____

Child's Specialist

Doctor's Name: _____ Type of Doctor: _____

Office Phone: _____ Fax: _____

Address: _____

Current medication prescribed:

Name of Medication	Dosage	Frequency	Start Date

Previous medication prescribed:

Name of Medication	Dosage	Frequency	Start Date & End Date

Please indicate the main reason for seeking counseling at this time: _____

_____

_____

_____

Parental Assessment of Child:

Check any of the following behaviors that most appropriately describe your child:

Feelings:

____Restless
____Sad
____Cries easily
____Overly guilty
____Angers easily
____Shows feelings that concern you or seem strange for his/her age
____Lacks remorse
____Sullen
____Fearful
____Bored easily
____Irritable

Behaviors:

____Has problems in school
____Does things that seem strange for age
____Destroys possessions or property
____Refuses to talk
____Overactive
____Has been in trouble with police
____Involved in sexual activity (pertaining to ages 10-17)
____ Threatens or harms other children
____ Threatens or harms animals
____ Lacks interest in things he/she usually enjoys
____ Steals
____ Sets fires
____ Hurts him/herself
____ Plays sexual games with others, toys, animals (pertaining to ages 3-9)

Social Interaction:

____Withdraws
____Doesn't look into other's eyes
____Clings to you often
____Defiant
____Argumentative
____Concerned about how child interacts with you
____Concerned about how child interacts with other family members
____Concerned about how child interacts with playmates/peers
____ Difficulty making friends
____ Difficulty keeping friends
____ Severe or frequent tantrums
____ Picks on others
____ Often gets in fights
____ Doesn't want to go to school
____ Prefers to be alone

Thinking:

____Concerned about child's thinking processes
____Daydreams often
____Has strange thoughts
____Difficulty trusting others
____Blames others for misdeeds or thoughts
____Has difficulty remembering things
____Frequently confused
____Distracted easily
____Decline in schoolwork/grades
____Sees or hears things that are not there
____Talks of death often
____Talks of suicide often

Physical Problems:

____Lack of energy
____Vomits often
____Sneaks food
____Wet pants
____Soils pants
____Has sleeping problems—nightmares, sleepwalking, early waking, frequent night waking
____Uses laxatives
____Refuses to eat
____Has stomach aches often
____Has headaches
____Has lost or gained a significant amount of weight
____Accident prone

Is there a family history of any of the following: (please mark any that apply and indicate who has the history)

____Alcohol Abuse	____Dyslexia	____Tics or Tourettes
____Drug Abuse	____Learning Disabilities	____Arrests
____Depression	____Oppositional Behavior	____Physical Abuse
____Anxiety	____Schizophrenia	____Sexual Abuse
____ADD/ADHD	____Bipolar disorder	____Seizures

Family Atmosphere (circle the number that best describes how you view your current family)

very lenient	1	2	3	4	5	very strict
very non-religious	1	2	3	4	5	very religious
chaotic	1	2	3	4	5	highly structured
few expectations	1	2	3	4	5	high expectations
inconsistent	1	2	3	4	5	consistent

School Performance

What subjects does your child consistently do well?

What subjects does your child consistently do poorly?

Grades tend to be: (check all that apply)

___ A ___ A-B ___ B ___Some C ___ All C ___C and below

Is your child expected to pass this school year? Yes No Unsure

For this school year, indicate the number of days absent from school: _____

How does your child typically handle homework?

____Does homework on their own	____ Forgets assignments at school
____Needs my help to do homework	____ Refuses to do homework
____Has to be constantly reminded to do homework	____Tries to do homework, but struggles to understand

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Child's Interests and Strengths

____Catching and throwing a ball	____Running fast	____Playing a musical instrument
____Dancing	____Art work	____Working with machines
____Building models	____Building things	____Writing stories/poems
____Working with electronics	____Telling stories	____Remembering where to find things
____Reading for pleasure	____Using his/her imagination	____Figuring out new reading words
____Caring for pets/animals	____Reading fast	____Learning new spelling words
____Understanding what he/she reads	____Handwriting	____Using a computer/game boy
____Learning about science	____Learning about history	____Other:_____
____Memorizing things for school	____Singing	
	____Playing a particular sport	

What strategies have you tried to help address the concerns you have with your child?

____Verbal reprimands	Results:_____
____Avoidance of child	Results:_____
____Giving in to the child	Results:_____
____Time out	Results:_____
____Removal of privileges	Results:_____
____Rewards	Results:_____
____Physical punishment	Results:_____
____Other_____	Results:_____

_____

Developmental History

Describe first three years of child's life.

At what age did they accomplish each milestone:

Sit up _____

Crawl_____

Walk_____

Say one word_____

Say 2-3 word sentences_____

Potty-trained_____

Engage with peers in playing_____

What helped them calm down when they were little?

Who were the primary caregivers from 0-3 years of age?

Any significant family changes during 0-3 years of age?

Trauma history

Has your child ever been physically abused? If yes, please describe.

Has your child ever been sexually abused? If yes, please describe.

Has your child ever been neglected (lack of food, dirty home, etc.)? If yes, please describe.

Has your child ever been traumatized in another way (natural disaster, car accident, etc.)? If yes, please describe.

Adoption history (only to be completed if child is adopted)

Age at which child was adopted:

Age at which child came into your home:

Why was child placed for adoption?

Is there contact with birth parents or birth siblings? If so, please describe.

How many homes or orphanages did child live in before your home (list places and dates)?

Describe your feelings about the adoption.

Any other information that you would like us to know: