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School Age Child Initial Meeting Information

Please fill out this questionnaire in as much detail as you feel comfortable. There may be things you do not know or cannot remember. That is fine. If you need to use the back or additional paper in answering a question, go right ahead. This is NOT a test. It is one way to get to know you. Only answer what you are ready to answer. Thanks!

Parent please complete this section:

Date:_____
Client Name:_____
Address:_____
Email Address (optional): _____
Home Phone:_ _____ Work Phone:_____
Cell Phone: _____Fax Number:_____
School:_____
Client SS#_____Gender:_____
Date of Birth:_____Age:_____
Physician:_____ Psychiatrist:_____
Allergies:_____
Medication(s):_____
Referred by:_____
Notify in Case of Emergency:_____
Relationship:_____
Daytime phone:_____
Insurance Coverage: _____yes _____no Company:_____
Policy Number: _____ Diagnostic Code: _____
Insured's Name : _____ and DOB:_____
Insured SS#: _____

Background History

Have you ever talked or played with a counselor before? _____yes _____no
If yes, where? _____School Guidance Counselor
_____Mental Health Clinic
_____Private Therapist
_____In-Patient Hospitalization
_____Other (please specify) _____

Are Your Parents? _____Married _____Separated _____Divorced
_____Father Deceased _____Mother Deceased _____Father Remarried _____Mother Remarried
Father's Job_____ Mother's Job_____
Were you adopted? _____ Did you experience foster care?_____
Do you have step-parents? _____ Name them _____
_____
Mention anything significant about your relationship with your parents or caregivers:
_____
_____
_____

Education of Father:
_____Did not finish high school
_____High school graduate
_____College degree
_____Graduate degree

Education of Mother:
_____Did not finish high school
_____High school graduate
_____College degree
_____Graduate degree

Number of Brothers: _____
Older: _____
Younger: _____
Half: _____

Number of Sisters: _____
Older: _____
Younger: _____
Half: _____

Where are you in the birth order? _____
Mention anything that stands out about your relationship with your siblings:
_____
_____
_____
Is there anyone else that plays a big role in your family life (grandparents, aunts, uncles, family friends…)? If so, please describe: _____
_____

_____
_____
_____
What form(s) of discipline are used in your family? _____
_____
Who disciplines you ? _____
_____
How is your home life? _____
_____
What do you like most about your family? _____
_____
_____
What do you dislike most about your family? _____
_____
Is there anything else you feel is important that has not been covered so far? _____
_____
_____
Have you ever been to court? _____yes _____no
If yes, for what reason? _____
What Happened? _____
Has anyone ever touched you in a way that made you feel uncomfortable or hurt you?

_____family member _____date or acquaintance
_____friend _____stranger
_____other (please specify)

Has anyone ever spoken to you in a way that made you feel uncomfortable or hurt you?

_____family member _____date or acquaintance
_____friend _____stranger
_____other (please specify)

Do you ever refuse food, overeat, or hide food? _____yes _____no
Please describe your feelings about food. _____
_____
Do you have any feelings you wish you could change? Please describe:
_____
_____

Do you have any behaviors you wish you could change? Please describe:
_____
_____

Please name any big changes in your life within the last six months to a year:
_____
_____

Who can you count on for support? _____
_____

What are your goals for counseling? _____
_____
_____

Emotional and Social Inventory

Circle the number that best fits your experience:	**1 None**	**2 A little**	**3 Some**	**4 Much**	**5 Very much**
Social Life and Relationship Skills					
Too little social life	1	2	3	4	5
Too much social life	1	2	3	4	5
Difficulty saying "no" to others	1	2	3	4	5
Difficulty meeting people	1	2	3	4	5
Have hard time with close relationships	1	2	3	4	5
Concerned about being racially harassed	1	2	3	4	5
Concerned about my sexual behavior	1	2	3	4	5
Difficulty communicating	1	2	3	4	5
Inability to make or keep friends	1	2	3	4	5
Hurting people's feelings	1	2	3	4	5
Feel like I don't fit in anywhere	1	2	3	4	5
Want to end a close relationship	1	2	3	4	5
Concerned about being sexually harassed	1	2	3	4	5
Afraid of losing someone I love	1	2	3	4	5
Concerned about someone else's sexual behavior	1	2	3	4	5
Conflicts with others	1	2	3	4	5
Worry about what others think of me	1	2	3	4	5
Too concerned about personal appearance	1	2	3	4	5
Unable to control my anger	1	2	3	4	5
Physical Health Issues					
Feeling stressed	1	2	3	4	5
Nightmares/Restless sleep	1	2	3	4	5
Appetite Loss	1	2	3	4	5
Headaches	1	2	3	4	5
Chronic or frequent illness	1	2	3	4	5
Weight concerns	1	2	3	4	5
Alcohol/Drug abuse	1	2	3	4	5
Lack of exercise	1	2	3	4	5
Too much energy	1	2	3	4	5
Under-eating	1	2	3	4	5
Overeating	1	2	3	4	5
Binging and purging	1	2	3	4	5
Emotional Health					

Feeling sad often and for long periods	1	2	3	4	5
Feeling irritable	1	2	3	4	5
Angry outburst or prolonged anger	1	2	3	4	5
Feeling anxious or nervous	1	2	3	4	5
Extreme mood swings	1	2	3	4	5
Crying easily and often	1	2	3	4	5
Feeling depressed for long periods	1	2	3	4	5
Hard time trusting people	1	2	3	4	5
Suicidal thoughts	1	2	3	4	5
Have attempted suicide	1	2	3	4	5

Family Issues

Being criticized by my parents	1	2	3	4	5
Parent expectations of me too high	1	2	3	4	5
Parent's divorce/separation problematic	1	2	3	4	5
Concerned about behavior of relatives, friends, or acquaintances	1	2	3	4	5
Sexual touch by family member(s)	1	2	3	4	5
My parents try to control me	1	2	3	4	5
Illness in my family	1	2	3	4	5
Bothered by events of the past	1	2	3	4	5
Concern about current family issues	1	2	3	4	5

Thank you for answering these questions. This will help me to k now how to help you. Feel free to address any or all of these issues with me as you feel comfortable. You can ask me anything or talk to me about anything!

Sincerely,

Miriam Lieberman, MA, LCMHCS
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