



For Counselor Use Only

Intake Date: _____	
Group/Counselor: _____	
Fee: _____	Previous Ct: Y N
Dates of Previous Counseling: _____	

Psychosocial History

Welcome to Trinity Family Counseling Services. To assist us in helping your child, please fill out this form as fully and openly as possible. All information is held in strictest confidence within legal limits. If certain questions do not apply to the child, please leave them blank.

FAMILY HISTORY

Mother's Name: _____

Mother's Age: _____

Father's Name: _____

Father's Age: _____

If parents are separated or divorced, how old was the child/adolescent when marital change occurred?

Please list all family members currently living at home or closely connected with the family. Indicate their ages, relationship to this minor and their school grade or occupation. Include parents who are currently residing with the child/adolescent.

Name	Age	Relationship	Grade/Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How does this child/adolescent get along with his/her brothers and/or sisters?

Describe any special activities that you do with this child/adolescent. _____

List the child/adolescent's main difficulties at home.

1) _____

2) _____

3) _____

Describe how this child/adolescent is disciplined. _____

For what reasons is this child/adolescent regularly disciplined? _____

SOCIAL DEVELOPMENT AND PEER RELATIONSHIPS

What special interest, hobbies, sports, and games does this child/adolescent enjoy both in and after school? _____

When this adolescent chooses friends, are they:

- Older Younger Own age All ages
- Boys Girls Both Boys and Girls

In activities, is this child/adolescent a leader, a follower, or a loner? _____

Does the adolescent prefer the company of adults to other peers his/her own age? ___ Yes ___ No

Does this child/adolescent have at least one best friend? ___ Yes ___ No

What is this friend's age? _____

Does this child/adolescent currently date? ___ Yes ___ No

Does this child/adolescent currently have a: ___ boyfriend ___ girlfriend

EMOTIONAL DEVELOPMENT

Has your child/adolescent ever been characterized by family members, teachers, or others as being:

- | | | | |
|----------------------|----------------|----------------|----------------|
| Restless/Inattentive | ___ Yes ___ No | Forgetful | ___ Yes ___ No |
| Humorous/Fun | ___ Yes ___ No | Quick to Anger | ___ Yes ___ No |
| Cheerful | ___ Yes ___ No | Depressed/Sad | ___ Yes ___ No |
| Daydreamer | ___ Yes ___ No | Disruptive | ___ Yes ___ No |
| Immature | ___ Yes ___ No | Happy | ___ Yes ___ No |
| Aggressive | ___ Yes ___ No | Nervous/Tense | ___ Yes ___ No |

Does this child/adolescent have a great many fears or worries? If so, what are they?

SCHOOL HISTORY

Briefly describe how this child/adolescent is doing in school. Note areas of strength and weakness in school. _____

What grades does this child/adolescent usually receive? _____

Have these changed lately? ___ Yes ___ No If yes, how? _____

Explain the circumstances if this child/adolescent has:

1) Had extended or frequent absences _____

2) Had to repeat a year _____

3) Changed schools in mid-year _____

4) Began school year at a new school _____

Has he/she had any remedial help or special education services in school or privately? ___ Yes ___ No

If yes, please describe and give approximate dates: _____

Please describe this child/adolescent's general attitude toward school. Note any special interests or dislikes he/she has in school. _____

How does this child/adolescent get along with the teacher and other students in school?

List this child/adolescent's main difficulties at school

MEDICAL HISTORY

Please describe this child/adolescent's general health. _____

Has he/she had any serious illnesses, accidents, or injuries? _____

Please give reasons and approximate dates for any hospitalizations.

Are there any conditions that require regular medical care?

Does he/she have any difficulties with vision or hearing? Note date and results of any previous vision or hearing examinations.

Does he/she have any allergies? ___ Yes ___ No If yes, please identify. _____

Name of pediatrician/family physician. _____

Date of last physical examination. _____

Please give any additional information that you believe would be helpful.
