Child & Family Guidance Center of Texoma
Current Concerns and Client History
Ages 3 to 17

Client Name: ________________________________ Age: ____ Gender ___M___F Ethnicity: ___________

Parent/Guardian Name(s): ___________________________________ Phone #: _______________________

Presenting Problem

Describe the problems you and/or your child are having and when they began: _________________________
____
____
____

What do you believe has contributed to the problem? ____
____
____
____

CURRENT CONCERNS: Please check all that apply and place a star next to the items of significant concern.	Mood Related Issues ___Anger ___Disturbing memories ___Difficulty going to sleep/staying asleep ___Nightmares/night terrors ___Suicidal thinking or talking ___Irritability ___Sadness/Depression ___Feelings of guilt and shame ___Excessive worrying/fear/anxiety ___Other (please specify) ______________	Behavioral/Conduct Issues ___Anger issues ___Aggression toward others ___Drug/Alcohol use ___Truancy ___Gang involvement ___Running away ___Stealing ___Intentionally hurting animals ___Fire-setting ___Other unusual behaviors (please specify) ________________
Family Relationship Issues ___Divorce ___Difficulty adjusting to family changes ___Discipline concerns ___Parent-Child relationship problems ___Sibling concerns ___Divorce/Separation ___Religious/Spiritual concerns ___Constant fighting ___Other (specify)____________________	Other Behavioral Concerns ___Sexual identity concerns ___Inappropriate sexual behavior ___Overeating/Refusal to eat ___Bedwetting or soiling ___Hyperactive/Impulsivity ___Inattentive ___Lying ___Oppositional/Defiant ___Grief/Loss ___Medical problems (please specify) ____ ________________________________ ___Other (please specify)______________	Work/School Issues ___Learning difficulties ___Problems with peers ___Problems with teachers ___Failing grades ___Refusing to go to school ___Peer/friend problems at school ___Other (please specify)____________

Treatment History:

1. Past or present counseling services received? ____No ____Yes When?__________________________
   Provider Name: ________________________________ How long? ____________________________
   Did treatment help you? ____No ____Yes
2. Past psychological evaluation: ____No ____Yes Please provide a copy of evaluation if possible.
3. Past hospitalizations for emotional or behavioral issues? ____No ____Yes
   When/Where ____
4. Current medications for mental health? ____No ____Yes
   Diagnosis__________________________ Prescription Name ________________________________
5. Is there a history of mental health issues in your family? ____No ____Yes
   Please list family members: ____

Family History:

1. Who do you live with now?____ Both parents ____Mother ____Father ____Other relative ____ Other
2. Do you have siblings? ____No ____Yes ____Brothers/Sisters ____Step or Half Brothers or Sisters
   How many? _______ Ages: ____________________________
3. Do you live with your siblings now? ____No ____Yes
4. Do you eat dinner together as a family at the table? ____No ____Yes How many times per week? ____
5. Estimated number of hours per day that you spend watching TV, listening to music, using a computer, on social media, or talking and texting on cell phone: _____
6. Who are some important people in your life? ____
7. Your life experiences growing up can affect your life. What experiences or events (divorce, grief, family violence, discipline, favoritism, trauma, affection, lack of attention, bullying, or others) have made a difference in your life? ____
   ____
   ____
   ____

Educational History

1. What grade are you in now? ______
2. Do you have any problems in school? ____ Academic____ Discipline____ Friends/Social____ Bullying
3. How has your attendance been this school year? ____ Excellent ____ Good ____ Poor
4. How have your grades been this school year? ____ Excellent ____ Good ____ Poor
5. What are your extra-curricular activities? ____
   ____
6. Do you have any learning difficulties or attend special classes? ____ No ____ Yes:_______________
   ____
7. If you work, how many hours per week? ________ Job Title: ________________________________

Social History

1. From whom do you get emotional support? ____
2. Do you have friends? ____ No ____ Yes How do you get along with your friends? _______________
3. Has there been a change in your circle of friends lately? ____ No ____Yes
4. What have been the losses, changes, crises and transitions in your life? _________________________
   ____
   ____
5. Do you have a belief system (cultural, moral, spiritual, religious, etc.) which influences your life? _____
   ____
6. Is there anything about your lifestyle (or your family or friends) that would be helpful for your therapist to know? ____
   ____

Medical History

1. Client's general health is? ____ Excellent ____ Good ____ Fair ____ Poor
2. List any allergies, serious illnesses, surgeries or injuries, hospitalizations: ______________________
   ____
   ____
3. What physical illnesses run in your family? ____
   ____
   ____
4. What is the name of your doctor/pediatrician? ____

Child & Family Guidance Center
Intake Questionnaire – Ages 12-17 years

The Child & Family Guidance Center of Texoma is striving to become a fully integrated trauma informed care organization. To help us better serve you, please complete this short questionnaire concerning possible life events. Thank you!

Name ____ **Date** ____________________

Stressful or scary events happen to many kids. Below is a list of stressful and scary events that sometimes happen. Mark YES if it happened to you. Mark NO if it didn't happen to you.

1. A serious natural disaster like a flood, tornado, hurricane, earthquake, or fire. Yes ☐ No ☐
2. Serious accident or injury like a car/bike crash, dog bite, sports injury. Yes ☐ No ☐
3. Robbed by threat, force or weapon. Yes ☐ No ☐
4. Slapped, punched, or beat up by someone in your family. Yes ☐ No ☐
5. Slapped, punched, or bear up by someone not in your family. Yes ☐ No ☐
6. Saw someone in your family slapped, punched or beat up. Yes ☐ No ☐

6a. Hearing someone in your family (or knowing about someone in your family) being slapped, punched or beat up. Yes ☐ No ☐

7. Saw someone in the community being slapped, punched or beat up. Yes ☐ No ☐
8. Someone older touched your private parts when they shouldn't. Yes ☐ No ☐
9. Someone forcing or pressuring sex when you couldn't say no. Yes ☐ No ☐
10. Someone close to you dying suddenly or violently. Yes ☐ No ☐
11. Attached, stabbed, shot at or hurt badly. Yes ☐ No ☐
12. Seeing someone attacked, stabbed, shot at, hurt badly or killed. Yes ☐ No ☐
13. Stressful or scary medical procedure. Yes ☐ No ☐
14. Being around war. Yes ☐ No ☐
15. Other stressful or scary event? Yes ☐ No ☐
    Describe: ____
    Which one is bothering you the most now? ______________________
16. Suicide attempted or completed by a family member. Yes ☐ No ☐
17. Suicide attempted or completed by a friend. Yes ☐ No ☐
18. Family members taken away by the police. Yes ☐ No ☐
19. Family members ill/sick for a long time. Yes ☐ No ☐
20. Family members dying. Yes ☐ No ☐
21. Being bullied. Yes ☐ No ☐
22. Being told that you are no good. Yes ☐ No ☐
23. Having to move. Yes ☐ No ☐

If you answered NO to all of the above questions, STOP.

If you answered YES to any of the above questions, please complete the rest of this form.

When the event happened, did you feel:

Afraid you would die or be hurt badly. Yes ☐ No ☐

Afraid someone else would die or be hurt badly. Yes ☐ No ☐

Helpless to do anything. Yes ☐ No ☐

Ashamed or disgusted. Yes ☐ No ☐