

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? _____

<p>CURRENT CONCERNS: Please check all that apply and place a star next to the items of significant concern.</p>	<p>Mood Related Issues</p> <p><input type="checkbox"/> Anger <input type="checkbox"/> Disturbing memories <input type="checkbox"/> Difficulty going to sleep/staying asleep <input type="checkbox"/> Nightmares/night terrors <input type="checkbox"/> Suicidal thinking or talking <input type="checkbox"/> Irritability <input type="checkbox"/> Sadness/Depression <input type="checkbox"/> Feelings of guilt and shame <input type="checkbox"/> Excessive worrying/fear/anxiety <input type="checkbox"/> Other (please specify) _____</p>	<p>Behavioral/Conduct Issues</p> <p><input type="checkbox"/> Anger issues <input type="checkbox"/> Aggression toward others <input type="checkbox"/> Drug/Alcohol use <input type="checkbox"/> Truancy <input type="checkbox"/> Gang involvement <input type="checkbox"/> Running away <input type="checkbox"/> Stealing <input type="checkbox"/> Intentionally hurting animals <input type="checkbox"/> Fire-setting <input type="checkbox"/> Other unusual behaviors (please specify) _____</p>
<p>Family Relationship Issues</p> <p><input type="checkbox"/> Divorce <input type="checkbox"/> Difficulty adjusting to family changes <input type="checkbox"/> Discipline concerns <input type="checkbox"/> Parent-Child relationship problems <input type="checkbox"/> Sibling concerns <input type="checkbox"/> Divorce/Separation <input type="checkbox"/> Religious/Spiritual concerns <input type="checkbox"/> Constant fighting <input type="checkbox"/> Other (specify) _____</p>	<p>Other Behavioral Concerns</p> <p><input type="checkbox"/> Sexual identity concerns <input type="checkbox"/> Inappropriate sexual behavior <input type="checkbox"/> Overeating/Refusal to eat <input type="checkbox"/> Bedwetting or soiling <input type="checkbox"/> Hyperactive/Impulsivity <input type="checkbox"/> Inattentive <input type="checkbox"/> Lying <input type="checkbox"/> Oppositional/Defiant <input type="checkbox"/> Grief/Loss <input type="checkbox"/> Medical problems (please specify) _____ <input type="checkbox"/> _____ <input type="checkbox"/> Other (please specify) _____</p>	<p>Work/School Issues</p> <p><input type="checkbox"/> Learning difficulties <input type="checkbox"/> Problems with peers <input type="checkbox"/> Problems with teachers <input type="checkbox"/> Failing grades <input type="checkbox"/> Refusing to go to school <input type="checkbox"/> Peer/friend problems at school <input type="checkbox"/> Other (please specify) _____</p>

Treatment History:

- Past or present counseling services received? ___No ___Yes When? _____
 Provider Name: _____ How long? _____
 Did treatment help you? ___No ___Yes
- Past psychological evaluation: ___No ___Yes Please provide a copy of evaluation if possible.
- Past hospitalizations for emotional or behavioral issues? ___No ___Yes
 When/Where _____
- Current medications for mental health? ___No ___Yes
 Diagnosis _____ Prescription Name _____
- 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 3-11 years

The Child & Family Guidance Center of Texoma is striving to become a fully integrated trauma informed care organization. To help us better serve your child, 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. Please answer to the best of your knowledge. Mark YES if it happened to your child. Mark NO if it didn't happen to your child.

- | | | |
|---|------------------------------|-----------------------------|
| 1. A serious natural disaster like a flood, tornado, hurricane, earthquake, or fire. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Serious accident or injury like a car/bike crash, dog bite, sports injury. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Robbed by threat, force or weapon. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Slapped, punched, or beat up by someone in your family. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Slapped, punched, or bear up by someone not in your family. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6. Saw someone in your family slapped, punched or beat up. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6a. Heard someone in your family (or knowing about someone in your family) being slapped, punched or beat up. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7. Saw someone in the community being slapped, punched or beat up. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 8. Someone older touched your child's private parts when they shouldn't. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 9. Someone forced or pressured sex when your child couldn't say no. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 10. Someone close to your child dying suddenly or violently. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 11. Attached, stabbed, shot at or hurt badly. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 12. Saw someone attacked, stabbed, shot at, hurt badly or killed. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 13. Stressful or scary medical procedure. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 14. Being around war. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 15. Other stressful or scary event? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Describe: _____ | | |
| Which one is bothering him/her the most now? _____ | | |
| 16. Suicide attempted or completed by a family member. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 17. Suicide attempted or completed by a friend. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 18. Family members taken away by the police. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 19. Family members ill/sick for a long time. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 20. Family members dying. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 21. Being bullied. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 22. Someone saying to your child that they are no good. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 23. Having to move. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

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 your child feel:

- | | | |
|---|------------------------------|-----------------------------|
| Afraid he/she would die or be hurt badly. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Afraid someone else would die or be hurt badly. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Helpless to do anything. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Ashamed or disgusted. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |