Stephen J. Terrell, MS, LPC, RPT, SEP
Licensed Professional Counselor #15575
8500 North MOPAC, Suite 701
Austin, Texas 78759
512-206-0260
512-206-0260 (fax)
steve@austinattach.com

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to the first session.

Child Intake Form:

Information supplied by: _____

Relationship: _____

Date: _____

PLEASE PRINT:

1) Name: _____

2) Age: _____ Date of Birth: _____

3) Gender: _____ 4) Height: _____

5) Weight: _____ 6) Eye Color: _____

7) Hair Color: _____ 8) Race: _____

10) Address: _____

City: _____ State: _____ Zip: _____

11) Home phone: _____ Cell phone: _____ 12)

School: _____ Year: _____

13) Has the child been involved in previous counseling?
If yes, please describe: _

_____

_____

_____

_____

14) Why is the child coming to counseling?

_____

_____

_____

15) How long has this problem persisted (from # 14)?

_____

_____

_____

16) Under what conditions do the problems usually get worse?

_____

_____

_____

17) Under what conditions are the problems usually improved?

_____

_____

Reasons for seeking therapy:

Reason:	Yes or No	Reason:	Yes or No
Reactive Attachment Disorder		Attachment Ruptures	
Developmental Trauma		Medical Trauma	
Single Incident Trauma		Shock Trauma	
Parenting Issues		Sleep Disturbance	
Post Traumatic Stress Disorder		ADD/ADHD	
Pre-Adoption Counseling		Post-Adoption Counseling	
Failed Adoption Counseling		Foreign Adoption Issues	
Mother / Child Attachment		Depression/Mood Disorders	
Personality Disorders		Anxiety	
Fear / Phobia		Nightmares/Night Terrors	
School Issues		Addictive Behaviors	
Oppositional Defiant		Other	

Medical History

1) Name and address of your primary physician:

   Physician's name:

   _____

   Address: _____ City: _____ State: ____ Zip: _____

   Most recent physical exam: _____

   Results:_____

   _____

2) Dental

Most recent exam: _____

Results: _____

3) Vision

Most recent exam: _____

Results: _____

4) Hearing

Most recent exam: _____

Results: _____

5) Current prescribed medications Dose Dates Purpose Side effects

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

6) Current over-the-counter meds Dose Dates Purpose Side effects

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

7) Immunization record (check immunizations the child/adolescent has received):

	DPT	Polio	
2 months	____	_____	15 months ___ MMR (Measles, Mumps, Rubella)
4 months	____	_____	24 months ____ HBPV (Hib)
6 months	____	_____	prior to school _____ HepB
18 months	____	_____	
4-5 years	____	_____	

8) List any major illnesses and/or operations:

_____

_____

_____

9) List any physical concerns occurring at present: (e.g., high blood pressure, headaches, and dizziness):

_____

_____

_____

10) List any physical concerns (e.g., head trauma, seizures) experienced in the past:

_____

_____

_____

11) On average how many hours does the child sleep daily?

_____

12.)Does the child have trouble falling asleep at night? ___Yes ___No

If yes, how long has this been a problem?

_____

Describe the child's appetite (during the past week):

_____ Poor appetite _____ average appetite _____ large appetite

Medical History (check all that apply):

__Abortion	__ Hay fever	__Pneumonia
__Asthma	__ Heart trouble	__Polio
__Blackouts	__ Hepatitis	__ Pregnancy
__ Bronchitis	__ Hives	__ Rheumatic Fever
__ Cerebral Palsy	__ Influenza	__ Scarlet Fever
__ Chicken Pox	__ Lead poisoning	__ Seizures
__ congenital problems	__ Measles	__ severe colds
__ Croup	__ Meningitis	__ severe head injury
__ Diabetes	__ Miscarriage	__ sexually transmitted disease
__ Diphtheria	__ Multiple sclerosis	__ Thyroid disorders
__ Dizziness	__ Mumps	__ Vision problems
__ Ear infections	__ Muscular Dystrophy	__ Wearing glasses
__ Eczema	__ Nose bleeds	__ Whooping cough
__ Encephalitis	__ other skin rashes	__ Fevers
__ Pleurisy	__ Paralysis	__ other

Chemical Use History

1) Does the child/adolescent use or have a problem with alcohol or drugs? ___ Yes ___ No
If yes, describe:

_____

_____

_____

Family History

1) With whom does the child live at this time?

_____

2) Is the child adopted or raised with parents other than biological parents?

___ Yes ___ No

3) Are parents divorced or separated?

_____

4) If parents separated or divorced, how old was the child then?

_____

5) If yes, who has legal custody?

_____

6) Were the child's parents ever married? ___ Yes ___ No

7) Is there any significant information about the parents' relationship or treatment toward the child, which might be beneficial in counseling? ___ Yes ___ No
If yes, describe:

_____

_____

8) What is the family relationship between the child and his/her custodial parents?

single parent, mother unmarried		single parent, father unmarried	
Parents Married		Parents Married but separated	
Parents Divorced		with mother and step-father	
with father and step-mother		relatives	
Adopted		foster care	

9) Is there a history of recent occurrence(s) of child abuse to this child? __ Yes __ No

If yes, which type(s) of abuse? __ Verbal __ Physical __ Sexual

Comments:

_____

_____

_____

Client's Parent 1

Name: _____ Age: _____

Occupation: _____FT ___ PT

Where employed: _____Work phone: _____

Education: _____

Is there anything notable, unusual or stressful about the child's relationship with Parent 1?

___ Yes __ No If Yes, please explain:

_____

_____

_____

How is the child disciplined by Parent 1?

_____

_____

_____

For what reasons is the child disciplined by Parent 1?

_____

_____

_____

_____

_____

Client's Parent 2

Name: _____ Age: _____

Occupation: _____FT ___PT

Where employed: _____ Work phone: _____

Parent 2 education:

_____

Is there anything notable, unusual or stressful about the child's relationship with Parent 2?

___ Yes ___ No If Yes, please explain:

_____

_____

How is the child disciplined by Parent 2?

_____

_____

For what reasons is the child disciplined by Parent 2?

_____

Client's Siblings and Others who live in the Household

Names of Sibling	Age	Gender	Bio/Adopt
1			
2			
3			
4			
5			
6			
7			
8			

Briefly describe the child's relationship with brothers and/or sisters:

Biological siblings:

Step/half siblings:

Adoptive siblings:

A DAY IN THE LIFE OF YOUR CHILD

Please write a description of a typical day in your child's life. Please include the following information and anything else that you think might assist in the treatment your child:

- Describe your child's typical behaviors.
- Describe how you would typically respond to these behaviors.
- Describe the interaction between your child and siblings.
- Which of your child's behaviors bothers you the most?
- Discuss your child's positive attributes.
- Describe your child's school behavior and your child's response to authority.
- Describe the community's (teachers, neighbors, friends, family) reactions to your child's behavior and to your parenting interventions.
- Describe how your child relates to mother and father.
- Describe what impact this child has had:
    - On your marriage
    - On your family
    - On your lifestyle
    - On your personal well being. (answer for each member of the family).
- Which of your parenting techniques seems to be the most effective? The most ineffective? What have you tried?
- How are you feeling? (answer for each member of the family)
- Does anyone in your family feel physically threatened?
- What are your worst fears?
- What are your best hopes?

Please be as thorough as possible.

Abuse Statement

- **Has a history of accusations of false abuse**
- **Is known to be self abusive**
- **Does not have a known history of accusations of false abuse**
- **Does not have a known history of self abuse**

Parent/Guardian **Date**

Parent/Guardian **Date**

Parents Autobiographies

To each parent: Please write your autobiography in paragraph form covering the following areas and any others you may find were/are significant in your life.

Family of Origin:

- Describe your mother and father (both strengths and weaknesses).
- How did your parents show affection to each other and their children?
- Describe your parent's marital history.
- Describe your parent's parenting philosophy.
- Describe your parent's means of motivation/discipline.
- Describe the communication style of your family of origin.
- How did your parent's handle disagreements and conflicts?
- How many siblings do you have and what role did each sibling play in family dynamics?
- Do you see any family patterns being repeated in your current family or in your siblings current families?
- Describe any changes in your family of origin, including: moves, job changes, significant events, deaths, separations from parents, divorce, major illness, or injuries.
- Describe your early childhood including any illnesses, hospitalizations, injuries, and separation from parents. Include significant memories, favorite activities, etc.

Current Family:

- Describe your current marriage/relationship (include both strengths and weaknesses).
- Write a brief description of any previous marriage(s).
- Describe your parenting philosophy.
- Describe your means of motivation/discipline.
- Describe any differences of parenting styles.
- Describe your communication styles.
- How are decisions made?
- Describe any current significant medical problems.
- List your children and give a brief description of each child.
- What concerns do you have with any other family member?
- Describe the family's support system.
- Describe your family's involvement with outside activities.
- How large of a role (if any) does religion play in your family?
- Describe your family's lifestyle.

Record of Child's out of Home Placements

Child's name: _____

Record as much information as you can. Begin with the current or most recent placement and work back in time. Placements should include hospitalizations and interim moves. Use additional pages if necessary.

Dates	Type of Placement	Caretaker's Name	Reason for move

*KEY: B-Birth BR-Birth Relative A-Adopt F-Foster S-Step IN-Institution R-Residential

INFORMED CONSENT

Please provide the information requested below. Your signature will indicate that you understand and accept the information contained in the ten-page document "Informed Consent Information".

Printed name: _____ Date of birth:_____

SSN: _____

Address: _____

City:_____State:_____Zip:_____

Email address:_____

Home phone: _____

OK to leave message (Y/N)?

Work phone: _____

OK to leave message (Y/N)?

Who referred you to this practice? _____

May I thank your referral source (Y/N)? _____

Will you want receipts to file for insurance reimbursement (Y/N)? _____

This acknowledges that I have read the HIPPA Privacy Form and may request a copy for my files. (Y/N).

_____

Signature Date

Please add on the other side of the page or on a separate page any other information you would like me to know about you and your situation.