

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):

<input type="checkbox"/> Abortion	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Polio
<input type="checkbox"/> Blackouts	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hives	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Influenza	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Lead poisoning	<input type="checkbox"/> Seizures
<input type="checkbox"/> congenital problems	<input type="checkbox"/> Measles	<input type="checkbox"/> severe colds
<input type="checkbox"/> Croup	<input type="checkbox"/> Meningitis	<input type="checkbox"/> severe head injury
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> sexually transmitted disease
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Thyroid disorders
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Mumps	<input type="checkbox"/> Vision problems
<input type="checkbox"/> Ear infections	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Wearing glasses
<input type="checkbox"/> Eczema	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Encephalitis	<input type="checkbox"/> other skin rashes	<input type="checkbox"/> Fevers
<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Paralysis	<input type="checkbox"/> 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.

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.