JENNIFER HILL
COUNSELING™

BACKGROUND INFORMATION:

Child's Name: _____
Date of Birth: _____
Age: _____ Home Phone: _____
Child's Address: _____

Child lives with:
Both biological parents ____ Mother ____ Father ____
Mother & Stepfather _____
Father & Stepmother ____
Other (specify): _____
If parents are divorced, describe custody arrangements:
_____

INFORMATION ABOUT CHILD'S MOTHER:
Mother's Name: _____ Age: _____
Occupation: _____ Hrs/wk: _____
Can you be contacted at work by phone? Yes _____ No _____
Work Phone: _____ Ext. _____
Religious Denomination: _____
Previous Counseling/Therapy? Yes _____ No _____ If yes, when?
_____
With whom and for how long?
_____

INFORMATION ABOUT CHILD'S FATHER:
Father's Name: _____ Age: _____
Occupation: _____ Hrs/wk: _____
Can you be contacted at work by phone? Yes _____ No _____
Work Phone: _____ Ext. _____
Religious Denomination: _____
Previous Counseling/Therapy? Yes _____ No _____ If yes, when?
_____
With whom and for how long?
_____

FAMILY MEMBERS:
List all people now living in the household, then list others who have lived there during the child's lifetime, include of all of following:

Name, Relationship to Child, Age, Occupation

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Has child had previous counseling? Yes _____ No _____ If yes, list names(s) of counselor(s), addresses, and dates of contact(s):

_____

_____

_____

Using a 0 – 10 number scale, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate every item, where 0 symbolizes "no concerns" and 10 symbolizes "extreme concern."

_____ Anger/Temper
_____ Talks of Suicide
_____ Depression
_____ Unhappy Most of the Time
_____ Divorce/Separation of Parents
_____ Use of Alcohol
_____ Adjustment to Parent's Remarriage
_____ Use of Other Drugs
_____ School Performance
_____ Work
_____ Family Problems
_____ Worry
_____ Fearfulness
_____ Self-esteem
_____ Physical Problems
_____ Poor Appetite
_____ Problems with Social Relationships
_____ Overeating
_____ Problems Sleeping
_____ Bedwetting
_____ Sexual Concerns
_____ Soiling
_____ Religious/Spiritual Concerns
_____ Cruelty to Animals
_____ Nightmares
_____ Other (specify): _____

Please add details for items rated as "extreme concern":
_____
_____
_____
_____
_____
_____
_____
_____

MEDICAL HISTORY:
Any complications surrounding child's birth? Yes _____ No _____
If yes, describe:

_____
_____

List child's sicknesses, operation, and injuries. Indicate age when occurred, and describe how severe:

_____
_____

List current medical problems:

_____
_____
_____

Is child currently taking any prescription drugs? Yes _____ No _____
If yes, please list:

_____
_____

Name of Physician: _____
Contact Phone: _____
Address: _____

ACADEMIC/SCHOOL INFORMATION:
Name of school: _____
Grade: _____ Teacher: _____
How does your child get along at school?

_____
Describe difficulties in learning at school:

_____
_____
Describe what your child likes to do, special interests, hobbies, etc.

_____
_____

Anything else you think would be important for the counselor to know:

_____
_____
_____
_____
_____