Lunday Counseling Center

4100 Legendary Dr., Suite 220, Bldg A
Destin, FL 32541
850-424-5515

Dx code: _____

CHILD TO COMPLETE ages 5-12

We understand that some of these questions may be difficult to answer or may not apply to you. Please do the best you can at answering these questions. The answers you give will help us to better understand where you are so we can help guide you during these life struggles.

Your Name: _____

Street Address: _____ City, State, Zip:_____

Can we write you here? Yes / No

Home Phone: _____ Cell Phone: _____

Can we leave a message? at Home: Yes / No Cell: Yes / No

Can we text you on your cell phone? Yes / No

Email: _____

Can we email you here? Yes / No

Birthday: _____

School :_____ Grade _____

Favorite class: _____

Hobbies _____

Who do you currently live with? _____

What is their relationship to you? _____

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PARENT TO COMPLETE

Welcome to Lunday Counseling Center. In order for us to gain a better understand of your child and his/her needs please complete the following information. Please answer questions to the best of your knowledge. Some questions may not apply to your child. Please write N/A to what does not apply. Any questions, let us know.

About you (parent)

Your Name: _____ Relationship to adolescent:_____

Street Address: _____ City, State, Zip:_____
Can we write you here? Yes / No

Home Phone: _____ Work Phone: _____ Cell Phone: _____
Can we leave a message at Home: Yes / No Work: Yes / No Cell: Yes / No

Email: _____
Can we email you here? Yes / No

Your Marital Status: □ Single

□ Married: How long? _____; When? _____ (mo/yr);

# of marriages _____

□ Separated: How long? _____; when? _____ (mo/yr)

□ Divorced: How long? _____; When? _____ (mo/yr)

□ Widowed: How long? _____; When? _____ (mo/yr)

Current Spouse's Name (if applicable) _____ Age _____

Spouse's Phone (in case of emergency): _____

Previous Spouse's Name(s) - *if applicable*: _____

Names of children

First name	Last name	Age	Lives in your home
_____	_____	_____	□ Yes □ No □ Part time
_____	_____	_____	□ Yes □ No □ Part time
_____	_____	_____	□ Yes □ No □ Part time
_____	_____	_____	□ Yes □ No □ Part time

Who can we contact in case of an **emergency**? (Must be an adult other than yourself)

Name: _____ Phone: _____

Address: _____ City, State, Zip:_____

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About your child (5-12)

MEDICAL INFORMATION

How would you rate your child's current physical health? □ Excellent □ Good □ Fair □ Poor
Is he/she currently experiencing any physical problems (e.g. headaches, body aches, stomach problems)? □ Yes □ No If yes, please explain: _____ Previous hospitalizations for medical reasons:

Date:_____ Reason: _____

Date: _____ Reason: _____

Medical conditions or disabilities: _____

Learning or other disabilities not listed: _____

Please list all non-psychiatric medications: (over the counter or prescription): Ex: Tylenol; Zyrtec

Medication	Dosage	Frequency	Reason for medication

Has your child ever abused prescription or non-prescription drugs? □ Yes □ No

If yes, which types? _____

COUNSELING AND PSYCHIATRIC INFORMATION

Has he/she had previous counseling? □ Yes □ No If yes, when? _____

Name and location of counselor: _____

If yes, for what reason? _____ For how long? _____

What were the results?_____

Has he/she ever been diagnosed or treated for any type of mental illness? □ Yes □ No

If yes, which type? _____

Please list any other disorders not already mentioned:_____

Has anyone in your family ever been diagnosed with or treated for any type of mental illness?□Yes□No

If yes, which type? _____

Has your child ever attempted to commit suicide or homicide? □ Yes □ No
If yes, when? _____ how? _____

Is there a history of suicide in your nuclear or extended family? □ Yes □ No

Is your child presently having thoughts of harming self or others? □ Yes □ N

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Please list all psychiatric medications: Ex: ADD/ADHD medication;

Medication	Dosage	Frequency	Reason for medication

Is your child currently seeing a physician or psychiatrist? □ Yes □ No

Physician's Name: _____ City, State: _____

Phone: _____

Psychiatrist's Name: _____ City, State: _____

Phone: _____

SCHOOL

Name of School: _____Teacher: _____ Grade: _____

Please describe any positive or negative changes your child is experiencing in school:

_____

_____

When did you first notice these changes?_____

What is your child's attitude toward school?_____

What are his/her major complaints about school?_____

_____

Has he/she changed schools recently? Yes/No If yes, when?_____

Does your child get along with teachers and other students? □ Yes □ No

Please Explain: _____

_____

REASON FOR SEEKING COUNSELING

What concerns or recent event has brought your child to counseling today? _____

_____

Please rate the severity of your child's concerns on the following scale.

Check one: □ Mild □ Moderate □ Severe □ Totally Incapacitating

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When did your child's present issues begin to be a problem? _____

_____

How are your child's concerns affecting you personally? Please check all that apply**:**

□ Home □ Marriage □ Children □ Health □ Job □ Finances □ Extended Family

□ Relationship with God □ Anger □ Stress □ Sadness/Depression □ Worry

Other: _____

BEHAVIORS OF CONCERN

Please check how often the following behaviors occur.

1) Loses temper easily	___Never	___Rarely	___Sometimes	___Frequently
2) Argues with adults	___Never	___Rarely	___Sometimes	___Frequently
3) Refuses adult's requests	___Never	___Rarely	___Sometimes	___Frequently
4) Deliberately annoys people	___Never	___ Rarely	___Sometimes	___Frequently
5) Blames others for own mistakes	___Never	___ Rarely	___Sometimes	___Frequently
6) Easily annoyed by others	___Never	___Rarely	___ Sometimes	___Frequently
7) Angry	___Never	___Rarely	___ Sometimes	___Frequently
8) Spiteful/Vindictive	___Never	___Rarely	___ Sometimes	___Frequently
9) Defiant	___Never	___Rarely	___ Sometimes	___Frequently
10) Bullies/Teases others	___Never	___Rarely	___ Sometimes	___Frequently
11) Initiates fights	___Never	___Rarely	___ Sometimes	___Frequently
12) Uses a weapon	___Never	___Rarely	___ Sometimes	___Frequently
13) Physically cruel to people	___Never	___Rarely	___ Sometimes	___Frequently
14) Physically cruel to animals	___Never	___Rarely	___ Sometimes	___Frequently
15) Stealing	___Never	___Rarely	___ Sometimes	___Frequently
16) Forced Sexual Activity	___Never	___Rarely	___ Sometimes	___Frequently
17) Intentional arson	___Never	___Rarely	___ Sometimes	___Frequently
18) Burglary	___Never	___Rarely	___ Sometimes	___Frequently
19) "Cons" other people	___Never	___Rarely	___ Sometimes	___Frequently
20) Runs away from home	___Never	___Rarely	___ Sometimes	___Frequently
21) Truant at school	___Never	___Rarely	___Sometimes	___Frequently
22) Doesn't pay attention to details	___Never	___Rarely	___Sometimes	___Frequently
23) Several careless mistakes	___Never	___Rarely	___Sometimes	___Frequently
24) Does not listen when spoken to	___Never	___Rarely	___Sometimes	___Frequently
25) Doesn't finish chores/homework	___Never	___Rarely	___Sometimes	___Frequently
26) Difficulty organizing tasks	___Never	___Rarely	___Sometimes	___Frequently
27) Loses things	___Never	___Rarely	___Sometimes	___Frequently

28) Easily distracted ___Never ___Rarely ___Sometimes ___Frequently
29) Forgetful in daily activities ___Never ___Rarely ___Sometimes ___Frequently
30) Fidgety/squirmy ___Never ___Rarely ___Sometimes ___Frequently

31) Difficulty remaining seated ___Never ___Rarely ___Sometimes ___Frequently
32) Runs/climbs around excessively ___Never ___Rarely ___Sometimes ___Frequently
33) Sexually Active ___Never ___Rarely ___Sometimes ___Frequently
34) Hyperactive ___Never ___Rarely ___Sometimes ___Frequently
35) Difficulty awaiting turn ___Never ___Rarely ___Sometimes ___Frequently

36) Interrupts others ___Never ___Rarely ___Sometimes ___Frequently
37) Problems pronouncing words ___Never ___Rarely ___Sometimes ___Frequently
38) Poor grades in school ___Never ___Rarely ___Sometimes ___Frequently
39) Expelled from school ___Never ___Rarely ___Sometimes ___Frequently
40) Drug abuse ___Never ___Rarely ___Sometimes ___Frequently

41) Alcohol consumption ___Never ___Rarely ___Sometimes ___Frequently
42) Depression ___Never ___Rarely ___Sometimes ___Frequently
43) Shy/avoidant/withdrawn ___Never ___Rarely ___Sometimes ___Frequently
44) Suicidal threats/attempts ___Never ___Rarely ___Sometimes ___Frequently
45) Fatigued ___Never ___Rarely ___Sometimes ___Frequently

46) Anxious/nervous ___Never ___Rarely ___Sometimes ___ Frequently
47) Excessive worry ___Never ___Rarely ___Sometimes ___Frequently
48) Sleep disturbance ___Never ___Rarely ___Sometimes ___Frequently
49) Panic attacks ___Never ___Rarely ___Sometimes ___Frequently
50) Mood shifts ___Never ___Rarely ___Sometimes ___Frequently
51) Violence ___Never ___Rarely ___Sometimes ___Frequently
52) Threatens Harm to others ___Never ___Rarely ___Sometimes ___Frequently

What are the top three behaviors that you would like to see changed.

1) _____

2) _____

3) _____

STRENGTHS/WEAKNESSES

List his/her three greatest weaknesses or needed areas of improvement.

1) _____

2) _____

3) _____

List his/her three greatest strengths.

1) _____

2) _____

3) _____

SOLUTIONS

What, if any, solutions have you found that are helping your child overcome his/her current issues? _____

_____

_____

DISCIPLINE

How do you currently discipline your child?

_____

_____

SPIRITUALITY

Which denomination(s) does your family follow most closely? _____

Does your family read or talk about the bible regularly? ☐ Yes ☐ No

Does your child attend church regularly? ☐ Yes ☐ No

If yes, which church does the child attend? _____

What is the denomination of this church? _____

Is spirituality important to your child? ☐ Yes ☐ No

How does your child respond to conversations about God and/or the Bible?

_____

Do you want your counselor to discuss spiritual issues with your child? ☐ Yes ☐ No

Referral information

How did you hear about Lunday Counseling Center?

☐ Friend _____ ☐ Daycare _____
☐ Church _____ ☐ Pastor/Minister _____
☐ Doctor's office _____ ☐ School _____
☐ Internet ☐ Other: _____

Can we thank them for the referral? _____ If so, make sure to put their name and contact info on space below. Thanks!

_____

Thank you so much for choosing Lunday Counseling Center.