

# Lunday Counseling Center

4300 Legendary Dr., Suite 218, Bldg C  
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
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Part time
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Part time
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Part time
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Part time

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

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

### About your child (5-12)

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## 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

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

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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:

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When did you first notice these changes? \_\_\_\_\_

What is your child's attitude toward school? \_\_\_\_\_

What are his/her major complaints about school? \_\_\_\_\_

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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: \_\_\_\_\_

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## REASON FOR SEEKING COUNSELING

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

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

Check one:  Mild  Moderate  Severe  Totally Incapacitating

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

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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               | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 2) Argues with adults                | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 3) Refuses adult's requests          | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 4) Deliberately annoys people        | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 5) Blames others for own mistakes    | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 6) Easily annoyed by others          | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 7) Angry                             | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 8) Spiteful/Vindictive               | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 9) Defiant                           | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 10) Bullies/Teases others            | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 11) Initiates fights                 | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 12) Uses a weapon                    | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 13) Physically cruel to people       | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 14) Physically cruel to animals      | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 15) Stealing                         | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 16) Forced Sexual Activity           | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 17) Intentional arson                | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 18) Burglary                         | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 19) "Cons" other people              | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 20) Runs away from home              | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 21) Truant at school                 | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 22) Doesn't pay attention to details | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 23) Several careless mistakes        | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 24) Does not listen when spoken to   | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 25) Doesn't finish chores/homework   | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 26) Difficulty organizing tasks      | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 27) Loses things                     | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 28) Easily distracted                | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 29) Forgetful in daily activities    | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 30) Fidgety/squirmy                  | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 31) Difficulty remaining seated      | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 32) Runs/climbs around excessively   | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |

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- |                                |                                |                                 |                                    |                                     |
|--------------------------------|--------------------------------|---------------------------------|------------------------------------|-------------------------------------|
| 33) Sexually Active            | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 34) Hyperactive                | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 35) Difficulty awaiting turn   | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 36) Interrupts others          | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 37) Problems pronouncing words | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 38) Poor grades in school      | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 39) Expelled from school       | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 40) Drug abuse                 | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 41) Alcohol consumption        | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 42) Depression                 | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 43) Shy/avoidant/withdrawn     | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 44) Suicidal threats/attempts  | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 45) Fatigued                   | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 46) Anxious/nervous            | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 47) Excessive worry            | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 48) Sleep disturbance          | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 49) Panic attacks              | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 50) Mood shifts                | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 51) Violence                   | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 52) Threatens Harm to others   | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> 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

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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 \_\_\_\_\_

Church \_\_\_\_\_

Doctor's office \_\_\_\_\_

Internet \_\_\_\_\_

Daycare \_\_\_\_\_

Pastor/Minister \_\_\_\_\_

School \_\_\_\_\_

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.