Counseling and Wellness Center of South Florida

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___Betsy Rose Rodriguez, M.S.
___Katalin Hanana, MS, LMHC
___Viviana Vethencourt, M.S., LMHC
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# Child/Adolescent Information

*Welcome to the practice. To speed up the initial process if you would please fill out this form as completely as possible, we will be able to get started quickly. All information provided will be kept confidential within the guidelines expresses in the Client Handbook. Thank you.*

**Please Print**

**Child Name**:______________________________ Date:____________ FILE #_________
Address:_________________________________________________________________
(City)___________________________________ State:_____________ Zip:___________
Age:___ Date of Birth:___/___/___ Male_ Female_

Place of Birth:___________________How long have you lived in Florida?__________
School/Grade:____________________________________________________________
Employed/Hours a week:___________________________________________________
Extra Curricular Activities/Hour a week:_____________________________________
_________________________________________________________________________
Describe the primary reason for coming to counseling:___________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

**Parents' Signatures**___________________________________

Whom may I thank for referring your family?
Name:________________________Address:_________________________________
City:_________________________State:______Zip:__________Phone:____________
We give our permission to send a letter of acknowledgment to our referral source:
_______________________________________________________________
(Parent Signature)

**Parent #1's Name**:______________________________
Address if different:_________________________________________________________
(City)___________________________________ State:_____________ Zip:___________
Age:___ Date of Birth:___/___/___ Male_ Female_

| | OK to Contact | | OK to send/leave message | |
|---|---|---|---|---|
| Email Address:_________________ | Y | N | Y | N |
| Home Telephone:_______________ | Y | N | Y | N |
| Work Telephone:_______________ | Y | N | Y | N |
| Cell Phone:_____________________ | Y | N | Y | N |

Place of Birth:___________________How long have you lived in Florida?__________
Military Service: Branch:______________ From_____________To________________
Education:_______________________________________________________________
Current Occupation:_______________________________________________________
Employed By:____________________________________________________________
Address;_________________________________________________________________
(City):_____________________________________State:____________Zip:_________

**Parent #2's Name**:______________________________
Address if different:_________________________________________________________
(City)___________________________________ State:_____________ Zip:___________
Age:___ Date of Birth:___/___/___ Male_ Female_

| | OK to Contact | | OK to send/leave message | |
|---|---|---|---|---|
| Email Address:_________________ | Y | N | Y | N |
| Home Telephone:_______________ | Y | N | Y | N |
| Work Telephone:_______________ | Y | N | Y | N |
| Cell Phone:_____________________ | Y | N | Y | N |

Place of Birth:___________________How long have you lived in Florida?__________
Military Service: Branch:______________ From_____________To________________
Education:_______________________________________________________________
Current Occupation:_______________________________________________________
Employed By:____________________________________________________________
Address;_________________________________________________________________
(City):_____________________________________State:____________Zip:_________

**Parents' Signatures**_____________________ ____________________________________

# Family Information

**Current Parents' Marital Status:**

Married: _ Divorced: _ Separated;_ Widowed: _ Co-Habitating:_
Single: _ Engaged: _ Other____________

**List all Child's household members:**

| Name | Age | Relationship | Occupation/(School/Grade) |
|---|---|---|---|
| 1.______________ | ________ | ________________ | _________________________ |
| 2.______________ | ________ | ________________ | _________________________ |
| 3.______________ | ________ | ________________ | _________________________ |
| 4.______________ | ________ | ________________ | _________________________ |
| 5.______________ | ________ | ________________ | _________________________ |
| 6.______________ | ________ | ________________ | _________________________ |

**Parent #1: Please list all of <u>your</u> marriages or significant relationships.**

| Name of Spouse | Date Married | Children from this Relationship | Terminated (Death/Date, Divorced/Date) |
|---|---|---|---|
| 1.____________ | ______________ | ________________ | __________________ |
| 2.____________ | ______________ | ________________ | __________________ |
| 3.____________ | ______________ | ________________ | __________________ |

**Parent #2: Please list all of <u>your</u> marriages or significant relationships.**

| Name of Spouse | Date Married | Children from this Relationship | Terminated (Death/Date, Divorced/Date) |
|---|---|---|---|
| 1.____________ | ______________ | ________________ | __________________ |
| 2.____________ | ______________ | ________________ | __________________ |
| 3.____________ | ______________ | ________________ | __________________ |

# Child Medical and Psychotherapy History

*Parents please fill out:*

Any Surgeries? Yes □ No □

| Procedure | Date | Comments/Outcome |
| --- | --- | --- |
| | | |
| | | |

Any current medical diagnosis or diseases? Yes □ No □

| Diagnosis | Date | Comments/Status |
| --- | --- | --- |
| | | |
| | | |

Any current treatments or therapies for these conditions? Yes □ No □

_______________________________________________

Family Impact of Diagnosis:

_______________________________________________

Any previous psychotherapy? Yes □ No □

| Date Started | Date Completed | Purpose of Therapy | Therapist |
| --- | --- | --- | --- |
| | | | |

How helpful was it? Much improved □ Somewhat improved □ Improved □
Worse □ Somewhat worse □ Much worse □ No change □

Any hospitalizations? Yes □ No □

| Date | Hospital | Reason |
| --- | --- | --- |
| | | |
| | | |

Current Medications:

| Medication | Dose | Prescribing Physician |
| --- | --- | --- |
| | | |
| | | |
| | | |

May I contact physician(s) to co-ordinate treatment? Yes □ No □
Parents' Signatures_______________________________________________

# Child Clinical Information

*Parents please fill out:*

Child Name: ________________ Parents' Signatures: _________________________

Please check all items that **your child** has experienced in the last 6 months:

**Physical Symptoms**

□ Headaches
□ Fainting Spells/ Dizziness
□ No appetite/Overeating
□ Stomach/ Bowel disturbances
□ Palpitations
□ Tremors – shaking
□ Poor sleep
□ Nightmares/ Night Tremors
□ Unusual bodily sensations
□ Sexual Problems
□ Tired/No Energy

**Emotional Symptoms**

□ Anxious
□ Depressed
□ Self-Esteem Issues
□ Fears/Worries
□ Inferiority feelings
□ Panic Attacks
□ Anger Issues
□ Feeling Tense/Stressed
□ Shy
□ Poor Decision Making
□ Lack Ambition or Interests
□ Unable to relax

**Social/Family Issues**

□ Marital/Partner problems
□ Parent/Child problems
□ Unemployed/Work Issues
□ Financial Problems
□ Court/Legal problems
□ Problems making/keeping friends

**Addictions**

□ Drinking problem
□ Drug Abuse
□ Gambling
□ Sexual Addiction
□ Food Addiction
□ Excessive Shopping

**Mental Health**

□ Previous Suicide Attempts
□ Suicidal Ideas
□ Visual Hallucinations
□ Hearing Voices
□ Disturbing thoughts or fears
□ Manic

□ Other___________________________________________________________

Please describe in detail those items checked above and for how long you have been experiencing each:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

# Clinical Information

*To be filled out by Child/Adolescent if able:*
Name: ______________________ Signature: _________________________________

Please check all items that **you** have experienced in the last 6 months:

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□ No appetite/Overeating
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______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________