



# CAPITOL PEAK COUNSELING, PLLC

Jennifer Worcester, MA, LPC

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This form is being completed by: \_\_\_\_\_

## Client Information:

Name of Child: \_\_\_\_\_

Parents Names: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Can I contact you at this email address? Yes No

Home Phone: \_\_\_\_\_ Can messages be left at this number? Yes No

Cell Phone: \_\_\_\_\_ Can messages be left at this number? Yes No

Other Phone Number: \_\_\_\_\_ Can messages be left at this number? Yes No

Date of Birth: \_\_\_\_\_ School Currently Attending: \_\_\_\_\_

Grade: \_\_\_\_\_ Teachers Name: \_\_\_\_\_

## Financial Responsibility:

Who is financially responsible for services? \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Policy Holder's Social Security # : \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

**Family History:**

Siblings Name:	Parents of Child:	Living in the Home: (Yes/No)	School Child Attends:

Are client's parents married?                      Yes /No      **If no, please answer the following 4 questions:**

1. Please describe custody arrangements: \_\_\_\_\_

2. Which parent has decision making authority in the following areas?

Education \_\_\_\_\_ Medical/Mental Health \_\_\_\_\_

3. Are client's parents currently in court regarding custody arrangements?                      Yes      No

4. Is there previous or current Child and Family Investigator (CFI) involved with family?      Yes      No

Has the child's family had any involvement with social services?                      Yes      No

Do you have any family history of mental illness? (Bipolar, Schizophrenia, Depression, etc.)      Yes      No

Do you have any family history of learning difficulties or behavior problems?                      Yes      No

Has child experienced and physical/sexual/emotional abuse?                      Yes      No

If you answered yes to any of the above questions, please provide additional information below:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Educational History:**

Schools Attended: (Most Recent First)	Teacher:	Any Problems Reported:

Has child ever had any of the following?

Individualized Education Plan (IEP)                      Yes                      No                      \_\_\_\_\_

504 Plan    Yes                      No                      \_\_\_\_\_

Individual Learning Plan (ILP)                              Yes                      No                      \_\_\_\_\_

Other services at school?                                      Yes                      No                      \_\_\_\_\_

Is child currently experiencing any problems at school?

\_\_\_\_\_

**Medical / Mental Health History:**

Pediatrician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date of last physical: \_\_\_\_\_ Date of last hospitalization: \_\_\_\_\_

Please list any previous counseling or other relevant treatment/therapies (counseling, occupational, speech, hospitalization, etc.):

Provider's Name:	Date Began:	Date Ended:

Has child ever been given a mental health diagnosis? \_\_\_\_\_

Please list any medications (prescription or nonprescription) that child is currently taking:

Medication:	Dosage:	Date Began:	Date Ended:	Prescribing Physician:

Please circle any of the following symptoms/conditions that child is or has experienced:

Headaches	Thoughts of Self Harm	Stress	Defiance
Dizziness	Depression	Anxiety	Hyperactivity
Head Injury	Diabetes	Feeling Out of Control	Difficulty with Attention
Fatigue	Abuse	Difficulty Sleeping	Poor Boundaries
Heart Trouble	Sexual Behavior Problems	School Problems	Restricted Interest
Irritability	Anemia	Difficulties Making Friends	Difficulty Learning
See or Hear Things that are not There	Allergies	Repetitive Behaviors	Rituals
Weight Gain or Loss	Legal Problems	Difficulty with Change	

Please list/describe any other medical disease/condition that child has experienced that is not mentioned above:

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**Other:**

What are your reasons for seeking counseling services at this time?

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Is there anything else you would like to share that was not asked above?

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How were you referred to Capitol Peak Counseling or Jennifer Worcester? \_\_\_\_\_