Date:___________________________

Self / Parent Evaluation

Name:__________________________ Date of Birth:________________________

Address:
____

Preferred Phone Number: ____________________________ Okay to leave messages: _______

What are your present concerns about *self*/child? ___________________________________

____

____

When did these challenges begin?____

What do you think is causing these challenges?____

____

What are your present concerns about how *you* or your family is functioning? ____________

____

What are *your*/child's interests?____

What are *your*/child's strengths?____

What are *your*/child's limitations?____

How do *you* hope that I can be of

Date:____________________________

help?____

____

Medical Providers

Primary Care Provider:________________________________
Phone:_________________________

Other providers (including mental
health):____

____

Other people in the family:

Name	Age	School/Grade	Living at home?	Relationship

____

____

____

***Spouse*/Family Information**

Wife/Mother's Name_______________________ *Husband*/Father's
Name____________________

Address_____________________________
Address__________________________________

Preferred Phone_____________________ Preferred
Phone_________________________

Email_______________________________
Email___________________________________

Date of Birth__________________________ Date of
Birth_____________________________

Edu/Profession_______________________
Edu/Profession__________________________

Married__________ Since_____________ Married_______________
Since_____________

Separated__________Since_____________ Separated_____________ Since___________

Date:___________________________

Divorced___________Since_____________ Divorced_____________
Since__________

Early Childhood History

Did mother or child experience any difficulties during pregnancy?_________________________

Were you/ or child born prematurely or at a low birth weight?___________________________

Have you / or child had any major health problems since birth?__________________________

If so, please describe____

Did you child reach all developmental milestones on time?______________________________

Have you or your child had any of the following challenges?

Eating_________ Sleeping_________ Speaking_________ Separation from parent_____________

Relating to other children_________________ Fears__________________

If so, please describe____

____

____

Family Mental Health History

- Addiction- Who:______________________ Drug of Choice____________________________
- Depression
- Thyroid
- Anxiety (including Obsessive Compulsive Disorder)
- ADD or ADHD
- Schizophrenia
- Lyme Disease
- Other ____

Client Mental Health History

- Addiction (If "Yes" see page 4)
- Depression
- Thyroid
- Anxiety (including Obsessive Compulsive Disorder)
- ADD or ADHD

- Schizophrenia
- Lyme Disease
- Other ____

What else should I know about your family's health history that might be helpful in our work together?
____
____

____
____

School

Grade:_________________ School:__________________
Teacher:________________________

Does your child enjoy school?____

Have there been any recent sudden or dramatic changes in school performance or interest level?____
___

Is there anything else I should know about you or your child's school experiences so far?____
___

Occupation

Profession: ___________________________
Position:____________________________________

Any major changes in the last 3 months?____

____
____

____
____

History of Addiction Continued:

Drug(s) of choice:____

Age of first use?____

Frequency of

Date:___________________________

consumption?____

Amount of
consumption/day?____

Attempts at
sobriety?____

Past treatment for
addiction?____

Where?____________________________________
When?___________________________________

Level of
Success?____

Family
Involvement/support?____

____
______

Additional Information

Please feel free to share any other information that you believe is important for me to know about you or your child and how I can help your family__________________________________

____
______

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______

Date:___________________________

____

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