FRC
Family Renewal Counseling, LLC

Thank you for choosing Family Renewal Counseling, LLC. We appreciate your trust in our services. This form will enable us to gain a quicker understanding of your child/teen (may be referred to as minor) and it will become a part of your confidential file. Please answer each question as completely as possible.

Client Name: _____ Age: _____

DOB: _____ SSN: _____

If student: _____
School Grade or College Class

If employed: _____
Employer Occupation

Referred by: _____ May we thank them? _____Y _____N

Home address: _____
Street City State Zip

Permission to send mail to above address: _____Y _____N

Person filling out this form: _____

Parent(s) or Guardian(s) with whom minor lives: _____

_____

Contact Information:	**Permission to Call:**	**Permission to Leave Msg:**
Home phone: _____	_____Y_____N	_____Y _____N
Parent's cell: _____ Please circle: Mom's or Dad's cell	_____Y_____N	_____Y _____N
Cell phone: _____	_____Y _____N	_____Y _____N

Primary Email: _____ Permission to use: _____Y ____N

Would you like appointment reminders at this email address?_____Y _____N

Mother's name: _____ DOB: _____

Address (If different from minor):

_____

Home phone: _____ Cell phone: _____

Occupation: _____ Work phone: _____

Revised 11/28/16

Father's name: _____ DOB: _____

Address (If different from child): _____

Home phone: _____ Cell phone: _____

Occupation: _____ Work phone: _____

Parent's marital status: Married: _____ Divorced: _____ Separated: _____ Never married: _____
Remarried: _____ How long? _____Other: _____
Date of divorce: _____ Date of remarriage_____

In case of emergency contact: _____
Name Phone

If parents are divorced:

Who has legal custody? ____ Mom ____Dad ____ Joint ____ Other

Who has physical custody?____ Mom ____ Dad ____Joint ____ Other

Who has medical decision making? ___Mom ___Dad___Joint ____Other

Stepparent's name: _____

Home Phone: _____ Cell phone: _____

Stepparent's name: _____ DOB: _____

Home Phone: _____ Cell phone: _____

Insurance Info. (If applicable) Fill out only if you wish us to file.

Insured's name: _____DOB: _____

Relationship to client: _____ SSN: _____

Name of Insurance Co.: _____

Group #: _____ ID #: _____

Phone #: _____

Employer: _____

Person responsible for charges: _____ Co-pay_____

Address & phone if different: _____

Other Payment Assistance. Fill out only if you wish us to charge the assisting party.

Name of person or organization: _____

Contact person and agreed terms: _____

_____

Client is responsible for keeping track of available funds during the therapy process.

Secondary Insurance Info. (If applicable) Filling this out gives us permission to file if necessary.

Insured's name: _____ DOB: _____

Relationship to client: _____ SSN: _____

Name of Insurance Co.: _____

Group #: _____ ID #: _____

Phone #: _____

Employer: _____

Person responsible for charges: _____

Address & phone if different: _____

Primary Care Physician: _____
Name Address Phone

Total gross family income: _____

*****In order to file insurance, benefits must be assigned. Otherwise, your payment will be full fee at time of service and not your co-pay. Do you agree to assign benefits to Family Renewal Counseling Center, LLC?**

_____yes _____no***

If you are eligible to file for insurance at FRC and choose not to do so, we will not file retroactively for services already rendered.

Religious/Cultural Background

What is your ethnic/cultural background?: _____

Religious Affiliation: _____ Church, Synagogue or Mosque: _____

Parents: Active _____ Inactive_____ Minor: Active _____ Inactive_____

Minor's Medical History

Current health status. Please list any illnesses, medications and prescribing physicians:

Illness	Medication/Supplement	Dosage/Frequency	Prescribing Physician

Please fill in any information you have on the areas listed below.

- Prenatal medical illness: _____

_____

- Premature Birth: _____

_____

- Birth Complications_____

_____

Check any problems during 1st year of life:

□ Allergies: _____

□ Sleep patterns or problems: _____

□ Any other medical problems: _____

_____

Developmental Issues: _____

_____

Check any:
□ Major childhood illnesses □ Hospitalizations □ Previous medications □ Allergies □ Head trauma
□ Important accidents and injuries □Surgeries □ Periods of loss of consciousness
□ Convulsions/seizures □ Other medical condition
Please list age and explanation: _____

_____

_____

Minor identifies as: ___Heterosexual ___ Lesbian: ___ Gay ___ Bisexual ___ Transgender ___ Other

Please list any special classes or therapies attended currently or in the past: _____

_____

Have there been any previous psychological, psychiatric, neurological or EEG evaluation? □ yes □ no

If yes, list provider and dates of service: _____

_____

Has minor had previous counseling? □ yes □ no If yes, please list name of counselor and date of contact:

_____

Has minor exhibited any self-harm behaviors? __yes __no If yes, please describe behavior and give

approximate time frame _____

Has child exhibited any suicidal or homicidal thoughts or actions? __yes __no If yes, please describe and

give approximate time frame _____

Has there ever been or is there current physical violence in home (ex shoving, hitting) __yes __ no If yes, please describe and give approximate time frame. _____

_____

Is there any reason your minor may feel unsafe in the home or elsewhere (ex school)? __ yes __ no If yes,

please describe _____

Residences

Please list all dates that the minor has lived in different residences, including location, with whom they were living (if different from current family), their reason for moving and any problems.

_____

_____

_____

Residential placements, institutional placements, or foster care - if applicable, please list dates that the minor was placed in a home, the program and location, the reason for the placement, and any problems.

_____

_____

_____

Education, self-care and social family/support

With whom does your minor currently live?

Name	**Relationship to Child**	**Birthday/Age**	**Biological, Step, Adopted, Foster**	**Who has primary custody?**

Name of ages of other children not in the home _____

_____

Describe minor's relationship with friends _____

Describe difficulties in learning at school _____

_____

_____

Describe any history of abuse, neglect or trauma_____

_____

Describe your minor's self-care and coping skills _____

_____

List hobbies, sports, recreational interests, TV, and toy preferences, etc. _____

_____

Describe your minor's school performance and experience _____

_____

Describe your minor's satisfaction with friends and social support _____

_____

Are there any issues with your minor's weight or eating habits?_____

_____

Describe your minor's exercise/activity patterns

_____

_____

Concerns Checklist

1. _____ Anger/Temper
2. _____ Depression
3. _____ Divorce/Separation of Patents
4. _____ Adjustment of Parent's Remarriage
5. _____ Physical or Sexual abuse
6. _____ School Performance
7. _____ Family Problems
8. _____ Conflict with Siblings
9. _____ Fearfulness
10 _____ Physical Problems
11._____ Problems with Social Relationships
12._____ Sleep Problems
13._____ Nightmares
14._____ Sexual Concerns
15._____ Religious/Spiritual Concerns
16. _____ Talk of Suicide
17. _____ Unhappy Most of the Time
18. _____ Use of Alcohol
19. _____ Use of Drugs
20. _____ Worry
21. _____ Self Esteem
22. _____ Poor Appetite
23. _____ Over Eating
24. _____ Bedwetting
25. _____ Soiling
26. _____ Cruelty to Animals
27. _____ Fire Setting
28. _____ Problems with concentration
29. _____ Grief/death of loved one
30. _____ Cutting,burning, self-harm

Below you will find statements about your child and any symptoms he or she may be experiencing. Circle the number below the word that best describes your child's behavior during the last 3 months. Please write under the statement any additional information that you feel would be helpful.

		Never	**Sometimes**	**Often**	**Always**
1.	My child continually seeks attention.	0	1	2	3
2.	I can see tension building up in my child.	0	1	2	3
3.	My child explodes under stress.	0	1	2	3
4.	My child has nervous habits like pulling at his/her clothing, clearing his/her throat, sniffing his/her nose, etc.	0	1	2	3
5.	My child cries easily.	0	1	2	3
6.	My child sucks his/her thumb/finger.	0	1	2	3
7.	My child rocks back and forth.	0	1	2	3
8.	My child shakes and trembles.	0	1	2	3
9.	My child complains he/she never gets a fair share of things.	0	1	2	3
10.	My child says people don't like him/her.	0	1	2	3
11.	My child is hyperactive and restless.	0	1	2	3
12.	My child becomes hysterical, upset or angry when things do not go his/her way.	0	1	2	3
13.	My child seems sad.	0	1	2	3
14.	My child becomes confused easily.	0	1	2	3
15.	My child walks or talks in his/her sleep.	0	1	2	3

16.	My child has trouble remembering things.	0	1	2	3
17.	My child complains he/she never gets a fair share of things.	0	1	2	3
18.	My child says people don't like him/her.	0	1	2	3
19.	My child tends to be selfish and self-centered.	0	1	2	3
20.	My child is very shy.	0	1	2	3
21.	My child is sensitive and has his/her feelings hurt easily.	0	1	2	3
22.	My child avoids competition.	0	1	2	3
23.	My child is a poor sport and poor loser.	0	1	2	3
24.	My child has trouble making friends.	0	1	2	3
25.	My child seems to have little self-confidence.	0	1	2	3
26.	My child does not get along with my husband/wife.	0	1	2	3
27.	There is a lot of arguing/fighting in our house.	0	1	2	3
28.	My child expresses concern about something terrible or horrible happening to family members or him/herself.	0	1	2	3
29.	My child expresses strong dislike for home and family.	0	1	2	3
30.	My child does not get along with his/her peers.	0	1	2	3
31.	My child says strange things for asks unusual questions.	0	1	2	3
32.	My child does strange things.	0	1	2	3
33.	My child often has small accidents or injuries.	0	1	2	3
34.	My child is a discipline problem at home.	0	1	2	3
35.	My child is a discipline problem at school.	0	1	2	3
36.	My child tells tall tales or lies.	0	1	2	3
37.	My child often throws temper tantrums.	0	1	2	3
38.	My child has attempted to seriously harm a person or animal.	0	1	2	3
39.	My child manipulates situations to his/her own benefit.	0	1	2	3
40.	My child does sexual things he/she shouldn't.	0	1	2	3
41.	My child seems to welcome punishment.	0	1	2	3
42.	My child disturbs other children by teasing, provoking fights or provoking others.	0	1	2	3
43.	My child steals things.	0	1	2	3
44.	I have to spank my child.	0	1	2	3
45.	My child voices an intense dislike of school.	0	1	2	3
46.	My child does not seem to be learning as he/she should.	0	1	2	3
47.	Teachers complain about my child.	0	1	2	3
48.	My child stares blankly into space and is unaware of his/her surroundings when doing so.	0	1	2	3

49. My child often complains of illnesses such as nausea, stomach pain or headaches.	0	1	2	3
50. One or more of my children also have problems.	0	1	2	3

Please circle YES or NO to the following statements as it pertains to your child.

1. My child's bowels move regularly.	YES	NO
2. My child is overweight or underweight. (underline which applies)	YES	NO
3. My child is in a special program at school.	YES	NO
4. My child may have a learning disability.	YES	NO
5. My child as a visual, hearing or speech problem.	YES	NO
6. My child has a chronic illness or handicap.	YES	NO

Other

What are your goals for treatment?_____

_____

What are your minor's goals for treatment? _____

_____

How will you know your goals are met? _____

_____

Is there anything else I should know that doesn't appear on this or any other forms, but might be important?: _____

_____

_____

_____

Is there anything you are hesitant to talk to me about? _____

_____

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