Fairview Counseling Center

For clients under the age of 18, Fairview Counseling Center requires the following:

1. Before a child or adolescent can be seen for their first visit, a legal guardian (usually a parent) must check in at the clinic's front desk to review and sign a Consent for Treatment.

2. A parent, legal guardian or other responsible adult must come with the child or adolescent to the first visit. They must be available to provide information to the therapist as needed.

3. If the adult who attends this visit is not a legal guardian, the legal guardian must complete and sign the enclosed Release of Information. This allows us to share information with the adult attending the session. This Release of Information must be given to the therapist before the child or adolescent can be seen for their first appointment.

Please complete the attached forms. Bring them with you to your first appointment.

Fairview Health Services
University of Minnesota Medical Center
Fairview Counseling Center

Medical, Psychological and Social History for Child or Teen

To be filled out by parent or legal guardian. *Date completed* _____________________

Please be as complete as possible when filling out this form. Bring the finished form to your child's first session. If you need help with this form, we will assist you at the first visit.

Name of child ___________________________________ **Age** _____ **Date of birth** _______________
(Month / Day / Year)

Person completing form _______________________________ **Relationship to child** _____________

Referred by: ☐ Insurance ☐ Doctor ☐ Other: ____

Emergency contact:_________________________________ **Phone** (______) ____________________

Is English your preferred language? ☐ Yes ☐ No

Is English your child's preferred language? ☐ Yes ☐ No

If you answered **no** to either question:

- What is the preferred language for you and your child? _____________________
- Would it help to have an interpreter or other support? ☐ Yes ☐ No

Describe any needs related to your culture or faith that might help us with your child's therapy:

____

____

***Office Use Only** — to be completed by therapist:*

MR#: _________________________ Account #: ___________________ Date of Service: ____________

People present at the interview: ____

(Names and relationships)

☐ Reviewed intake for and referral information

☐ Reviewed informed consent

☐ Completed release of information as indicated

Present Concerns *(If you need more space to write, please use notes section on next page.)*

What has led you to seek help for your child at this time?

____

____

What have you done to try to resolve your concerns? Who have you talked to about these concerns?

____

____

____

Please describe any stressors that may be affecting your child today (divorce, relationship changes, unemployment, school, peers, losses, etc.). **Note changes in your child's mood or behavior:**

____

____

____

____

How are these concerns affecting you and your family?

____

____

____

List one or two things that will be different when your concerns are resolved:

____

____

____

Please describe your child's strengths:

____

____

____

____

____

NOTES: (Additional space for Present Concerns, if needed)_____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

Family and Social History

Please describe the child's parent(s): ☐ Married to each other ☐ Partners/significant others
☐ Separated ☐ Divorced ☐ Single ☐ Remarried ☐ Widowed ☐ Other ___________________

List family and household members. *(Use more paper if needed)*

Name	Age	Relationship to child	Job, if employed	Living in same house as child? *(circle)*
				Yes No
				Yes No
				Yes No
				Yes No

Is your child living with someone other than birth or adoptive parents? ☐ Yes ☐ No

If yes, list legal guardians ____________________________________ Phone (____) ______________

Describe custody/placement: ____

____

If parents are not legal guardians, please bring documents regarding legal custody arrangements to the child's first visit.

Is your child having relationship problems with family members? ☐ Yes ☐ No

If yes, please explain: ____

____

____

Has your child ever been involved with the legal system? (truancy, probation, child protection, etc.)
☐ Yes ☐ No
If yes, please explain: ____

____

Probation officer or social worker ______________________________ Phone (_____) _____________

Developmental History *(If you need more space to write, please use notes section on page 7.)*

Were there any complications at the child's birth? ☐ Yes ☐ No
During the pregnancy? (mom's chemical use, nutrition, illnesses, etc.) ☐ Yes ☐ No

If so, please explain: ____

____

____

Has your child ever had any illnesses, medical problems or injuries? (broken bones, head injuries, surgeries, etc.) ☐ Yes ☐ No

If so, please explain: ____

____

____

Please note any major delays your child may have had: *(Check all that apply)*

- ☐ **Speech.** Age at which skill was developed: ____________________
- ☐ **Sitting, crawling, walking.** Age at which skill was developed: ____________________
- ☐ **Toilet training.** Age at which skill was developed: ____________________
- ☐ **Sleeping through the night.** Age at which skill was developed: ____________________

Has your child ever been separated from either parent for a period of time? ☐ Yes ☐ No

If so, please explain: ____

____

____

Has your child had problems separating from parents or primary caregivers? ☐ Yes ☐ No

If so, please explain: ____

____

____

Has your child ever had significant trauma? (assault, injury, bullying, discrimination) ☐ Yes ☐ No

If so, please explain: ____

____

____

Has your child ever had a significant loss? (death, divorce, moving, new school, disability, loss of pet)
☐ Yes ☐ No

If so, please explain: ____

____

____

Are you concerned that your child is being—or has been—abused (physically, sexually or emotionally)? ☐ Yes ☐ No

If so, please explain: ____

____

____

Has your child ever had nightmares, problems falling asleep or trouble sleeping through the night? ☐ Yes ☐ No

If so, please explain: ____

____

____

Do you or your child have any questions or concerns about the child's sexual activity, identity or orientation? ☐ Yes ☐ No

If so, please explain: ____

____

____

Are you talking to your child about drug use, smoking and sex? ☐ Yes ☐ No

Is this an area that you would like us to address in therapy? ☐ Yes ☐ No

NOTES: (Additional space for Developmental history, if needed) ______________________________

School Information

Name of school ______________________________ **Grade** __________

Has your child ever been held back or advanced beyond a grade level? ☐ Yes ☐ No

If so, please explain: ______________________________

____

____

Has your child ever been tested for or involved in any special education programs?
(Title I, speech, etc.) ☐ Yes ☐ No

If so, please explain: ______________________________

____

____

Does your child have problems in any of these areas? *(Check all that apply)*

☐ Speech ☐ Hearing ☐ Reading ☐ Writing ☐ Concentration/focus ☐ Attention
☐ Other: ______________________________ ☐ None

Have you ever had problems getting your child to go to school? ☐ Yes ☐ No

If so, please explain: ______________________________

____

____

Child's grades before this year: ☐ Low (D, F) ☐ Average (C) ☐ Above average (A, B)
Child's grades this year: ☐ Low (D, F) ☐ Average (C) ☐ Above average (A, B)

Has your child been diagnosed with ADD or ADHD? ☐ Yes ☐ No
If so, please bring documents from the assessment to your child's first visit.

Does your child get along well with peers? ☐ Yes ☐ No

If so, describe his or her friends: ☐ Younger ☐ Near own age ☐ Older

Do you have concerns about your child's friends? ☐ Yes ☐ No

If so, please explain: ____

____

____

Does your child have a best friend? ☐ Yes ☐ No

Is your teen dating? ☐ Yes ☐ No

Medical Information

Does your child have a primary care clinic or doctor? ☐ Yes ☐ No

Name of clinic or doctor: ____

Phone (____)____________________ Date of last doctor's visit: ______________________________

Has your child had an exam to rule out physical causes of current symptoms? ☐ Yes ☐ No

Date of last dental exam: ______________________________

Does your child have a psychiatrist? ☐ Yes ☐ No

Name of clinic or doctor: ____

Phone (____)____________________ Date of last doctor's visit: ______________________________

Have you discussed mental health concerns with your child's primary care doctor? ☐ Yes ☐ No

Does your child have any major medical problems? (chronic illness, injury, seizures) ☐ Yes ☐ No

If so, please explain. Note possible effects on emotional or mental health: ________________________

____

____

____

Does your child have problems with acute or chronic pain? ☐ Yes ☐ No

If so, please explain. Note any effects on sleep, appetite, mood and other areas:

____

____

____

Do you or your child have any concerns about his or her nutrition, eating patterns or weight?

☐ Yes ☐ No

If so, please explain: ____

____

____

In the past year, has your child had screening or testing for the following? *(Check all that apply)*

☐ **Vision.** If so, does your child have or need glasses or contact lenses? ☐ Yes ☐ No

☐ **Hearing.** If so, does your child have or need a hearing aid? ☐ Yes ☐ No

If a doctor has prescribed glasses or a hearing aid, does the child wear them? ☐ Yes ☐ No ☐ N/A

Is your child taking any medicines (prescribed or over-the-counter) or herbal products?

☐ Yes ☐ No If so, please list below:

Current Medicines (include prescribed, over-the-counter and herbal medicines)			
Medicine Name	*Dose / How Often*	*Reason*	*Doctor who prescribed it*

Has your child ever had any allergies or reactions to medicines? ☐ Yes ☐ No

If so, please explain: ____

Mental Health

Has your child ever received therapy or school counseling, stayed in the hospital, or taken part in a treatment program for mental health issues? ☐ Yes ☐ No If so, please explain:

Dates	Therapist or Clinic	Treatment Focus

Please list any of the child's blood relatives who have experienced the following:

Depression or bipolar disorder: ______________________________

Anxiety (including panic attacks, PTSD, OCD, phobias): ______________________________

Schizophrenia: ______________________________

ADHD: ______________________________

Eating disorders: ______________________________

Suicide: ______________________________

Chemical Dependency

Has your child ever had counseling, stayed in the hospital, or taken part in a treatment program for drug and alcohol issues? ☐ Yes ☐ No If so, please explain:

Dates	Therapist or Clinic	Treatment Focus

Have you—or anyone else—ever had concerns about your child's alcohol or drug use?
☐ Yes ☐ No

If so, please explain: ____

____

____

Have any of the child's blood relatives had issues with drug or alcohol use? (parents, grandparents, aunts, uncles, etc.) ☐ Yes ☐ No

If so, please explain: ____

____

____

Substance Abuse

Please describe use of the following: *(Check box if using; note how often)*

Alcohol: ☐ Child uses _____ times per day/week ☐ Parent uses _____ times per day/week

Tobacco: ☐ Child uses _____ times per day/week ☐ Parent uses _____ times per day/week

Caffeine: ☐ Child uses _____ times per day/week ☐ Parent uses _____ times per day/week

Marijuana: ☐ Child uses _____ times per day/week ☐ Parent uses _____ times per day/week

Other *(ecstasy, meth, inhalants, cocaine, etc.):* ____

☐ Child uses _____ times per day/week ☐ Parent uses _____ times per day/week

Non-medical use of prescribed or over-the-counter drugs
(Vicodin, Percocet, Ritalin, etc.): ____

☐ Child uses _____ times per day/week ☐ Parent uses _____ times per day/week

Describe any bad effects that drugs and alcohol have had on your child or family (social, legal, money, job, education, extra-curricular activities)**:**

____

____

Safety Concerns

Has your child ever injured him- or herself on purpose? Had thoughts about self-injury?
(cutting, burning, etc.) ☐ Yes ☐ No

If so, please explain: ______________________________

____

____

Has your child ever thought about or attempted suicide? ☐ Yes ☐ No

If so, list date and method: ______________________________

____

____

Does your child have a current suicide plan? ☐ Yes ☐ No

Has your child ever had thoughts of harming other people or their property? Has he or she ever done this? ☐ Yes ☐ No

If so, please explain: ______________________________

____

____

To your knowledge, are there firearms in your home? ☐ Yes ☐ No

If there are, how many and of what type (pistol, revolver, rifle, automatic)? ____________________

____

Do children or teens have access to these firearms? ☐ Yes ☐ No

Are these firearms stored unloaded and locked with trigger guards? ☐ Yes ☐ No
(You can get trigger guards free of charge from the local police department.)

Is the ammunition kept in a separate location? ☐ Yes ☐ No

Current Symptoms

Over the past **2 weeks**, how often has your child had problems with the following?

	Not at all	**Several days**	**More than half the days**	**Nearly every day**	***Therapist's notes***	***Onset***	***1=Mild 2=Moderate 3=Severe***
Symptoms							
Feeling sad							**1 2 3**
Crying without knowing why							**1 2 3**
Problems concentrating							**1 2 3**
Sleeping more or less than normal							**1 2 3**
Wanting to eat more or less than normal							**1 2 3**
Seeming withdrawn or isolated							**1 2 3**
Low self-esteem, poor self-image							**1 2 3**
Worry							**1 2 3**
Fears or phobias							**1 2 3**
Nightmares							**1 2 3**
Startles more easily							**1 2 3**
Avoids people, situations							**1 2 3**
Irritable and angry							**1 2 3**
Strives to be perfect							**1 2 3**
Behaviors							
Hyperactive							
Tells lies							**1 2 3**
Defiant							**1 2 3**
Aggressive							**1 2 3**
Shoplifts or steals							**1 2 3**
Sets fires							**1 2 3**
Problems with attention or focus							**1 2 3**

	Not at all	Several days	More than half the days	Nearly every day	*Therapist's notes*	*Onset*	*1=Mild 2=Moderate 3=Severe*
Stays up all night							1 2 3
Acts out sexually							1 2 3
Gets into fights							1 2 3
Cruel to animals							1 2 3
Compulsively checks things, washes hands or puts things in order							1 2 3
Too much TV, Internet, or computer games							1 2 3
Other							
Relationship problems with parents							1 2 3
Relationship problems with peers							1 2 3
Relationship problems with siblings							1 2 3
Recent grief:							1 2 3
Other:							1 2 3
Other:							1 2 3
Other:							1 2 3
Other:							1 2 3

How many hours per week does your child spends in the following:
Internet use: __________ Computer or video games: __________ TV: __________

Do you use blocking devices for the computer, TV or Internet? ☐ Yes ☐ No

Is the computer in an open area in your home? ☐ Yes ☐ No

Is there any other information you would like the therapist to have? ______________________________

____

____

Reviewed by ________________________________ Date __________ Time __________
(Therapist signature and credentials)

Adolescent Form

☐ *NA (strike through unused pages)*

To be completed by client (12 to 18 years). *Date:* ________________

Thank you for taking time to fill out this form. Please fill it out as completely as you can.
You will provide very helpful information to the counselor who will be meeting with you.
Bring the completed sheets with you to your first session.

1. **Who made the decision to set up this appointment?** ____
2. **What did your parents tell you about this appointment?** ____________________________________
3. **Do you think it's important for you to see us?** ☐ Yes ☐ No

   If yes, what issues have you been having lately? ____

   ____

   ____

4. **What have you done to try to resolve these issues?** ____

   ____

   ____

5. **What would you like to be better in your life?** ____

   ____

   ____

6. **What are your parents/guardians doing for you that is helpful?** ____________________________

   ____

7. **What could your parents/guardians do to be more helpful?** _________________________________

   ____

8. **Do you take part in after-school activities?** (sports, scouts, theater, music, etc.) ☐ Yes ☐ No

   If yes, what are these activities and how often are you involved?

   ____

   ____

9. How would your friends describe you? ____

____

____

Do you agree with how your friends see you? ☐ Yes ☐ No

10. What are you good at? ____

11. What's going well in your life? ____

____

____

12. Are you dating? ☐ Yes ☐ No If yes, how long have you been in this relationship? ________

13. If you could have three wishes that would improve your life, what would they be?

1. ____
2. ____
3. ____

14. What would you like to be when you grow up? ____________________________________

15. How much time do you spend on the following each day:

____________	Video or computer games	____________	With friends
____________	Homework	____________	Alone
____________	MySpace, YouTube, Facebook,etc.	____________	With family
____________	TV	____________	At a job

Do your parents express concern about the amount of time you spend on any of these things? ☐ Yes ☐ No

16. Check all that apply:

☐ In the past, I have used more than one chemical (drug or alcohol) at the same time to get high.
☐ I sometimes avoid family activities so I can use drugs or alcohol.
☐ I have a group of friends who use drugs or alcohol.
☐ I use drugs or alcohol to improve my emotions, such as when I feel sad or depressed.

17. Please check off all chemicals that you use. Describe each.

Type	How often (times per day or week)	Amount used	What does it do for you?
☐ Alcohol			
☐ Tobacco			
☐ Caffeine			
☐ Marijuana			
☐ Other (ecstasy, meth, inhalants, cocaine, etc.): ____________ ____________			
☐ Non-medical use of prescribed or over-the-counter drugs (Vicodin, Percocet, Ritalin, etc.): ____________ ____________			

18. Do you believe you have a problem with chemicals? ☐ Yes ☐ No

19. How would you know if you had a problem with them? ______________________________

____

20. Have you shared the information on these three pages with your parents? ☐ Yes ☐ No

COMMENTS: ____

____

____

Reviewed by ____ Date ______________ Time ________
(Therapist signature and credentials)