

**CHILD PROBLEM SCREENING FORM**

Child’s Name: Child’s DOB: Age:

Rater’s Name: Relationship to Child: Date:

Directions: Below is a list of ways that children may act, think, or feel.

Please 1. Circle the umber showing how often your child has behaved this way in the past 3 months.

 2. Circle “Yes” if it is currently a problem or “No” if it is not a problem.

|  |  |  |
| --- | --- | --- |
|   | **How often does this occur?** | **Is this a problem now?** |
| **Never** | **Seldom** | **Sometimes** | **Often** | **Always** |
| 1 | Argues with others | 1 | 2 | 3 | 4 | 5 | Yes | No |
| 2 | Can't concentrate or pay attention | 1 | 2 | 3 | 4 | 5 | Yes | No |
| 3 | Acts sad or depressed | 1 | 2 | 3 | 4 | 5 | Yes | No |
| 4 | Feeding or eating problems | 1 | 2 | 3 | 4 | 5 | Yes | No |
| 5 | Teases or fights with others | 1 | 2 | 3 | 4 | 5 | Yes | No |
| 6 | Is teased | 1 | 2 | 3 | 4 | 5 | Yes | No |
| 7 | Appears lonely | 1 | 2 | 3 | 4 | 5 | Yes | No |
| 8 | Can't sit still, hyperactive | 1 | 2 | 3 | 4 | 5 | Yes | No |
| 9 | Too fearful or anxious | 1 | 2 | 3 | 4 | 5 | Yes | No |
| 10 | Disobeys at home | 1 | 2 | 3 | 4 | 5 | Yes | No |
| 11 | Disobeys at school | 1 | 2 | 3 | 4 | 5 | Yes | No |
| 12 | Moody | 1 | 2 | 3 | 4 | 5 | Yes | No |
| 13 | School problems (academic) | 1 | 2 | 3 | 4 | 5 | Yes | No |
| 14 | Has temper tantrums or hot temper | 1 | 2 | 3 | 4 | 5 | Yes | No |
| 15 | Acts without thinking, impulsive | 1 | 2 | 3 | 4 | 5 | Yes | No |
| 16 | Threatens/tries to hurt others | 1 | 2 | 3 | 4 | 5 | Yes | No |
| 17 | Has low self-esteem | 1 | 2 | 3 | 4 | 5 | Yes | No |
| 18 | Toileting problems (wetting/soiling) | 1 | 2 | 3 | 4 | 5 | Yes | No |
| 19 | Self-conscious or easily embarrassed | 1 | 2 | 3 | 4 | 5 | Yes | No |
| 20 | Needs to be perfect | 1 | 2 | 3 | 4 | 5 | Yes | No |
| 21 | Threatens/tries to hurt animals | 1 | 2 | 3 | 4 | 5 | Yes | No |
| 22 | Threatens/tries to hurt self | 1 | 2 | 3 | 4 | 5 | Yes | No |

**PARENT QUESTIONNAIRE**

Date: Form Completed by: Relationship to Child:

Child’s Name: M F DOB: Ethnicity:

Address:

First Guardian’s Name and Cell Phone:

Second Guardian’s Name and Cell Phone:

Child’s Primary Physician:

Child’s Medications:

**FAMILY**

Father’s Name: DOB:

Address (if different from above):

Occupation: Educational level: # of dependents:

Mother’s Name: DOB:

Address (if different from above):

Occupation: Educational level: # of dependents:

Date of Marriage: Present Marital Status:

With whom does the child live? Birth Parents: Adoptive Parents:

Foster Parents: Other (specify):

List all other persons living in the home:

 Name Age Relationship to Child Present Health

List any other people who care for the child a significant amount of time

Name Relationship to Child (grandmother, neighbor, etc.)

**CHILD**

Pregnancy and Birth: Any complications? If yes, briefly explain

At what age did your child:

Sit without support Walk Begin talking Stay dry through the night

Has your child had any medical complications? If yes, briefly explain

Please list any jobs or chores your child has at home or How well does your child do these chores?

school (feeding the dog, making the bed, safety patrol) Poor Average Great

 1 2 3 4 5

 1 2 3 4 5

 1 2 3 4 5

What are your child’s strengths?

How many close friends does your child have? None 1 2-3 4+

How many times a week does your child do things with them? None 1 2-3 4+

Compared to other children their age, how well does your child get along with other children?

Poor Average Great

1 2 3 4 5

What are your child’s favorite play or after school activities?

**FAMILY AND PERSONAL HEALTH HISTORY**

Date of last physical examination Child’s height Child’s weight

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Check condition and relationship of any blood relative who has or has had any of the conditions listed below. | Child being seen | Father | Paternal Grandfather | Paternal Grandmother | Paternal aunt/uncle | Mother | Maternal Grandfather | Maternal Grandmother | Maternal aunt/uncle | Siblings | Other |
| Alcoholism/Substance Abuse |   |   |   |   |   |   |   |   |   |   |   |
| Allergies |   |   |   |   |   |   |   |   |   |   |   |
| Birth Defects |   |   |   |   |   |   |   |   |   |   |   |
| Cancer |   |   |   |   |   |   |   |   |   |   |   |
| Colitis |   |   |   |   |   |   |   |   |   |   |   |
| Depression |   |   |   |   |   |   |   |   |   |   |   |
| Heart Attack |   |   |   |   |   |   |   |   |   |   |   |
| High Blood Pressure |   |   |   |   |   |   |   |   |   |   |   |
| Migraine |   |   |   |   |   |   |   |   |   |   |   |
| Mental Illness |   |   |   |   |   |   |   |   |   |   |   |
| Seizure Disorder |   |   |   |   |   |   |   |   |   |   |   |
| Intellectual Disabilities |   |   |   |   |   |   |   |   |   |   |   |
| Learning/Attention Problems |   |   |   |   |   |   |   |   |   |   |   |
| Suicide/Suicide Attempt |   |   |   |   |   |   |   |   |   |   |   |
| Other (specify) |   |   |   |   |   |   |   |   |   |   |   |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Family Member | Living? Yes/No | Age | Health | If deceased, cause of death |
| Good | Fair | Poor |
| Father |   |   |   |   |   |   |
| Mother |   |   |   |   |   |   |
| Brothers |   |   |   |   |   |   |
|   |   |   |   |   |   |   |
| Sisters |   |   |   |   |   |   |
|   |   |   |   |   |   |   |

**DISCIPLINARY STRATEGIES**

Who generally disciplines the child?

What methods are used?

Are these methods effective?

Do parents agree on methods of discipline? Elaborate, if no

**SCHOOL HISTORY**

Has child been enrolled in nursery or day care? At what age?

Has child attended kindergarten? At what age?

Has child begun elementary school? At what age?

Present grade and school Does not go to school

If your child has ever been to school (including nursery, kindergarten, and grade school) complete the following for all classes beginning with nursery and ending with current placement. Please indicate if your child has an IEP or 504 plan.

Grade School Comments Regarding Behavior/Adjustment

Current School Performance

Reading Failing Below Average Average Above Average

Writing Failing Below Average Average Above Average

Spelling Failing Below Average Average Above Average

Math Failing Below Average Average Above Average

 Failing Below Average Average Above Average

 Failing Below Average Average Above Average

 Failing Below Average Average Above Average

 Failing Below Average Average Above Average

**PARENTAL CONCERNS**

What do you feel is your child’s main problem?

What do you feel caused your child’s problem?

What have you been told by doctors, teachers, and/or others about your child’s problems?

Has this child had any other mental health evaluations or treatment?

Has any member of the child’s immediate family had mental health treatment?

Other comments



**CONSENT FOR TREATMENT FOR CHILDREN AND ADOLESCENTS**

Client’s Name Therapist’s Name

1. All clinic files are confidential and my written consent is required for any release of information by the clinic to any ither persons outside Refine Counseling except in the following circumstances: (a) court order and subpoenas, (b) to defend legal action against Refine Counseling, (c) need to prevent clients from harming him/herself or others, and (d) suspected child abuse/neglect. If I request that the Refine Counseling submit reimbursement forms for your insurance, complete confidentiality cannot by agreed. If I file a lawsuit related to mental health issues, Refine Counseling’s records may also be accessed by the court.
2. I understand that my child’s willingness and ability to use counseling depend a great deal on the confidentiality he/she is allowed to maintain in the therapeutic setting. While I have the right to access my child’s file. I understand that doing so may jeopardize the therapeutic process. I agree to consult with my child’s therapist about any questions I have concerning the content of my child’s file or sessions.
3. I may be asked to sign consent forms for the release of social, medical, and/or psychological information from other agencies or individuals for the use by the staff of this clinic in my child’s/my own assessment or treatment. I may request restrictions on the use/disclosure of information in my child’s fie for treatment, payment, and health care operations purposes, but the therapist is not bound to agree with my request.
4. I understand that it is impossible to assure privacy of any communication by electronic means (email, texts, faxes). Email and text should never be used to communicate any urgent matter to the therapist.
5. Information from clients’ files may be complied to study various issues such as treatment outcomes and client satisfaction. My child’s name or any identifying information will not be use in such research.
6. Refine Counseling does not provide after-hours services. My therapist and I will set appointments. For after-hours emergencies, I should call 911.
7. The practice of psychology and related disciplines is not an exact science, and I acknowledge that no guarantees have been made to me regarding the results of treatment, assessments, and consultations. I understand that I am responsible for working with my child’s therapist to help ensure better treatment outcomes.
8. Refine Counseling is not a medical doctor; therefore, she cannot prescribe medications and is not authorized to practice medicine. If my therapist thinks that I should consider medication as a part of treatment, and I want to try this, my therapist will refer me to a physician with whom they would work to provide coordinated services. I understand that psychological problems can have medical or biological origins and I should have regular physical exams and speak with the doctor about all my symptoms.
9. I consent for myself and/or my child to undergo all testing and treatment procedures necessary to address the problems for which I am seeking help. I understand that I have the right to be informed of the nature and purpose of any procedure and that I can refuse or discontinue testing or treatment at any time.
10. I understand I am responsible for any fees for services to which I consent, and that failing to pay such fees may result in the termination o any further services ot me. Payment is due at the beginning of my appointment. I must cancel at least 24 hours before a session, unless my therapist and I both agree my cancellation was due to an emergency, or I am responsible for the session fee before I can schedule a new session. Continued non-payment of fees may result in action including being referred to a collection agency.
11. I understand that special arrangements may need to be made regarding payment and reporting of assessment and treatment results in cases of divorce, foster care, and court-mandated services.
12. I acknowledge that my therapist has reviewed the General Consent for Treatment for Children an adolescents form with me and I have been given a copy to keep for my own records.

Signature of Guardian Date

Printed Name of Guardian Relationship to Client

Signature of Child or Adolescent Date

Signature of Therapist Date