Mosaic Counseling Center, PLLC
92 Cornerstone Dr., #107
Cary, NC 27519

Identifying Information:

Client Name: _____ Date: _____

Date of Birth: _____ Male _____ Female _____

The information in this form is very important to your counselor, who will be reviewing it with you. It is also very important to the success of your treatment that your counselor understands as much about you as possible. Please answer the questions as honestly as you can, and feel free to explain or add any other information. If a question does not apply to you or your situation, please write N/A. This information, like all other information you provde, is confidential.

Presenting Problems:

1. Please describe the primary reason for seeking counseling, i.e. substance abuse, self-harm, eating disorder, depression, anxiety, etc.

_____
_____
_____

2. Do you think this is a very important problem? If yes please explain:

_____
_____
_____

3. How long has this been a problem?

_____
_____
_____

4. Is this a recurrent problem? Yes _____ No _____

5. Has this affected you and your family? If so please explain how.

_____
_____
_____

6. Does your child believe he/she has a problem? Yes _____ No _____

7. Does anyone in your child's immediate or extended family have a similar problem? Please explain.

_____
_____
_____

Family/Cultural History:

1.What is your child's ethnicity?

_____

2. Do you, your child, or your family identify with a particular cultural or ethnic group? Please explain.

_____
_____
_____

3. Has this played an important role in any current problems with your child? Please explain.

_____
_____
_____

4. In whose custody has your child spent most of his/her childhood?

_____
_____
_____

5. In what city or area has your child been raised?

_____

6. What is the Father's name, age, and job? If deceased, how and when?

_____
_____
_____

7. What is the Mother's name, age, and job? If deceased, how and when?

_____
_____
_____

8. If applicable, what is the Step-Father's name, age, and job? If deceased, how and when?

_____
_____
_____

9. If applicable, what is the Step-Mother's name, age, and job? If deceased, how and when?

_____
_____
_____

10. Is you child adopted? Yes No

11. If so, does he/she know about his/her birth parents? Yes _____ No _____

12. With whom does your child live?

13.How is he/she disciplined?

14.By whom is he/she disciplined?

15. If any, what are the names, ages, and genders of any siblings including step and half siblings? Do they live in the same place as him/her?

16. Please write any significant family history (include marriages, separations, substance/pyshical abuse, violence, death, disruptions, suicide/homicide).

17. How is your family supported?

- Parent/Guardian Employment
- Public Assistance _____
- Other, please explain

18. Are there any Family legal issues? (sexual abuse, custody, foster care, etc.)

19. Has your child had legal circumstances (i.e. criminal, wardship, custody, foster care)? Please explain

20. Who in your family is your child closest to? Please explain.

21. Have any deaths or losses affected your child? Please explain.

Developmental History:

1. Pregnancy and birth information (length of pregnancy, birth length and weight, etc.)

2. Milestones (walk, talk, toilet trained, etc):

3. Pre-natal exposure to Alcohol, Tobacco and Other Drugs (ATODs)? Yes _____ No _____
If yes, please describe:

4. Please list immunizations and date received:

5. Major illness (type/age of onset):

6. Allergies (type/age of onset):

7. Current medications, start date of meds, and name of prescribing doctor:

8. Has he/she ever had any kind of head injury? If so, when and how?

9. Has he/she ever lost consciousness as the result of an injury? If so, when and how?

_____
_____
_____

10. Has he/she ever had any of the following? If so, please indicate child's age when occurred.

- ☐ frequent nightmares; age _____
- ☐ sleep walking; age _____
- ☐ thumb sucking; age _____
- ☐ stuttering; age _____
- ☐ nail biting; age _____
- ☐ excessive fear; age _____
- ☐ bed wetting; age _____
- ☐ soiling; age _____
- ☐ difficulty with language/speech; age _____
- ☐ difficulty with hearing; age _____
- ☐ difficulty with vision; age _____
- ☐ trouble with police; age _____
- ☐ trouble with authorities; age _____
- ☐ temper problems; age _____
- ☐ sexual activity; age _____
- ☐ pregnancy (self or girlfriend); age _____
- ☐ cigarette use; age _____
- ☐ alcohol use; age _____
- ☐ gambling; age _____
- ☐ criminal acts/non-violent; age _____
- ☐ criminal acts/violent; age _____
- ☐ truancy from school; age _____
- ☐ running away from home; age _____
- ☐ gang membership or participation; age _____
- ☐ involvement with weapons; age _____
- ☐ suicide attempts; age _____
- ☐ eating disorder; age _____
- ☐ mood difficulties; age _____
- ☐ mental illness; age _____
- ☐ fire starting; age _____
- ☐ treatment/mental health; age _____
- ☐ treatment/substance abuse; age _____
- ☐ hurt animals; age _____

11. Has he/she had any learning difficulties? If so, please explain.

_____
_____
_____

12. How many schools has he/she attended?

_____
_____
_____

13. Reasons for change of school?

_____
_____
_____

14. Does your family belong to a spiritual organization? If so, which?

_____
_____
_____

15. Does your child attend/participate? Yes _____ No _____

16. Does he/she like participating? Please explain.

17. Will this affect treatment? If so, how?

18. Is he/she sexually active? Yes _____ No _____Unsure _____

19. Has he/she ever been sexually abused? If so, please explain, including who abused him/her.

20. Does he/she use birth control? If yes, what type?

21. Does he/she practice safe sex techniques, if applicable?

22. Please indicate if your child has ever had any of the following?

- ☐ depression
- ☐ fears
- ☐ paranoid or suspicious thoughts
- ☐ seeing or hearing things
- ☐ low self-esteem
- ☐ nervousness
- ☐ hurting self
- ☐ anxiety
- ☐ suicidal thoughts or attempts
- ☐ panic attacks
- ☐ sleep problems
- ☐ guilt
- ☐ fighting
- ☐ mood swings
- ☐ memory problems
- ☐ irrational beliefs
- ☐ appetite disturbances
- ☐ frequent headaches
- ☐ frequent stomach aches
- ☐ frequent gastric upset
- ☐ feeling helpless
- ☐ feeling hopeless
- ☐ feeling inadequate
- ☐ setting fires
- ☐ hostile feelings or actions
- ☐ hurting animals
- ☐ strange, unexplained thoughts, sensations, or feelings
- ☐ poor concentration

23. Does he/she watch TV or play videos? If so, how many hours per day are spent at this activity?

24. Which types of shows or movies does he/she prefer?

25. How much leisure time do you spend with your child?

26. Are you satisfied with your child's use of leisure (non-school) time? Please explain.

27. Does he/she eat a well balanced diet? What types of food do they eat daily?

28. Do you think your child has an eating problem? If so, please explain.

29. What types of vitamins/food supplements does he/she take and how often are they taken?

30. Does he/she avoid any of the major food groups? If so, which?

31. Would you like a referral to a dietitian for your child?

32. What do you hope your child will receive from treatment?

33. What will happen if your child's problems are not resolved through this treatment?

34. Please list any past treatment your child has received, including the dates, purpose, and person providing treatment.

35. Is there anything else you would like to tell us in order to help us understand your child and his/her situation?

Signature:

_____ _____
Client/Parent or Guardian Signature Date

_____ _____
Therapist Signature Date