Life Solutions: Family Counseling and Coaching Center
3550 Parkwood Blvd Suite A 201
Frisco, Texas 75034
(214) 995-0007

Child &Adolescent Intake
(Parent's Form)

Date_____

Referral Source_____

Welcome to Life Solutions! I thank you for making your first appointment I would appreciate it if you would please review and sign this paperwork, where indicated. Please bring all signed documents in addition to a copy of your driver's license and current insurance card (if you are expecting Life Solutions to file claims with your insurance company.) I am looking forward to working with you.

Respectfully,
Mahnaz Sadre, Ph.D., LMFT-S, LMFT-S

Attention Child's Legal Guardian Managing Conservator: if the child is not living with both natural parents, both adoptive parents, or the only living parent, please be advised that **this practice requires a photocopy of the most recent legal document stating custody arrangements. Services will NOT be rendered if no copy is produced.**

Parent/Legal Guardian's Name _____
Last First Middle

Child's Information

Child's Name _____
Last First Middle

Child's Birth date_____Grade _____ Social Security # _____

Address _____
Street City/State Zip Code

Home Phone_____Permission to leave message? Yes_____No _____

Mobil/Pager_____Permission to leave message? Yes_____No _____

Primary Physician:_____Phone: _____

Emergency Contact_____Phone: _____

Emergency Contact Address: _____

Relationship to Emergency Contact: _____

Parents/Guardian Information

Mother's Name_____Mom's SS# _____

Mom's Address:_____Phone: _____

Mom's Employer_____Occupation: _____

Work Phone:_____Permission to contact Mom at work? Yes_____No _____

Mother's Marital Status Married____Separated_____Divorced_____Remarried_____Number of Marriages_____ Never Married ____

History of emotional/mental health related issues: Yes____No _____

If yes, please explain: _____

History of behavioral/conduct problems: Yes____No _____

If yes, please explain: _____

History of Suicide Attempts: Yes____No _____

If yes, please explain: _____

History of impatient psychiatric care: Yes____No _____

If yes, please explain: _____

History of addiction: Yes____No _____

If yes, please explain: _____

History of family violence: Yes____No _____

If yes, please explain: _____

Father's Name:_____Dad's SS# _____

Dad's Address:_____Phone: _____

Dad's Employer_____Occupation: _____

Work Phone:_____Permission to contact Dad at work: Yes____No _____

Father's Marital Status Married____Separated_____Divorced_____Remarried_____Number of Marriages_____Never Married _____

History of emotional/mental health related issues: Yes_____No _____

If yes, please explain: _____

History of behavioral/conduct problems: Yes_____No _____

If yes, please explain: _____

History of Suicide Attempts: Yes_____No _____

If yes, please explain: _____

History of impatient psychiatric care: Yes_____No _____

If yes, please explain: _____

History of addiction: Yes_____No _____

If yes, please explain: _____

History of family violence: Yes_____No _____

If yes, please explain: _____

If the child's biological parents are divorced, how long was the marriage? _____

How long have they been divorced? _____

How old was the child when the divorce happened? _____

Is the child adopted? Yes_____No _____ If yes, when? _____

Custody arrangement: What type of custody: Joint_____Primary_____Temporary _____

Who has the custody: Mother_____Father_____Grandparent(s) _____

If other, please specify _____

Are you currently involved in a custody dispute? Yes_____No_____If yes, please explain: _____

If divorced, mark which of the following describes your relationship with your ex-spouse:
Hostile_____Maddening_____Frustrating_____Friendly_____Great _____

I understand that I must provide Dr. Sadre at Life Solutions with the most current court papers regarding custody arrangement. Initials _____

Social/Family Information

People currently living in the household:

Name	Relationship to client	Age	Education level	Occupation
1.				
2.				
3.				
4.				
5.				
6.				

Immediate family members living elsewhere:

Name	Relationship to client	Age	Education level	Occupation

Medical/Mental Health History Information

Would you be willing to be a part of your child's therapy? Mom Yes____No ____
Dad Yes____No ____

Has your child ever been hospitalized for psychiatric or mental health reasons? Yes___No___If yes, please indicate where, when, how long, and for what reasons _____

_____

Has your child ever been seen by another counselor/psychologist? Yes ____ No ____

Is your child currently receiving counseling elsewhere? ___ Yes ___ No

Has your child ever been evaluated by a psychiatrist? Yes ___ No ___ If yes, please indicate psychiatrist's name _____

Is your child currently under treatment by a physician for any medical condition?___Yes ___ No; If yes, please describe: _____

_____

Is your child taking any prescribed, over the counter or herbal medication? Yes ___ No ___ If yes, please indicate the names and dosage of the medication(s) as well as the prescribing physician's name _____

_____

Does your child suffer from allergies or asthma? Yes___ No ___ If yes, is it under control?

If yes, how? _____ For how long? _____

Risk Assessment

In the last 48 hours has your child reported any thoughts of harming themselves or other(s)?

___ Yes____No____Self____Other(s)

Has your child ever been suicidal?____Yes____No; if yes, please describe: _____

Has your child ever engaged in self-injurious behavior (cutting, burning, skin picking, scratching)? ___ Yes ___ No; if yes, please explain: _____

Are there any guns or weapons in your house? ___ Yes ___ No; if yes, please specify whose and what type: _____

Has a family member or close friend ever committed suicide? ___ Yes ___ No; if yes, please indicate relationship and by what means: _____

Is there a family history of mental illness or substance abuse? ___ Yes ___ No, If yes, indicate relationship and diagnosis: _____

Do you have any reason to believe your child is using any substances? ___ Yes ___ No; if yes, please describe: _____

Is there any personal history of: Emotional abuse ___ Yes ___ No, Physical abuse ___Yes ___ No, Sexual abuse ___ Yes ___ No; if yes, has any abuse been reported to authorities? ___ Yes ___ No; if yes please explain: _____

_____

Do you have any reason to believe that your child is sexually acting out or engaging in high-risk sexual behavior?____Yes_____No; if yes, please explain: _____

_____

Has your child ever been involved in any significant legal actions, currently or in the past (e.g.: lawsuit, probation?) if yes please state under what circumstances: _____

_____

Education

Child's current school name: _____

Child's teacher's name: _____

What were your child's grades on his/her last report card? _____

Has your child met with the school counselor?____Yes_____No

School problems:_____Academic problems_____Discipline problems____Social problems
___ Other, please explain: _____

What complaints does your child have about school, please describe: _____

_____

Is your child in Special Ed? Yes___ No___ If yes please specify _____

Has your child ever been tested/assessed through the school district? ___ Yes ___ No; **if yes, please bring a copy of the results for Dr. Sadre to review.**

Behavioral/Emotional

Please check any of the following that are typical for your child:

___ Trouble with friends	___Frustrated easily	___Sad	___ Aggressive
___ Selfish	___ Refusing to go to school	___ Guilt/shame	___ Fearful
___ Separation Anxiety	___Angry	___ Hallucinations	___ Sets Fires
___ Anxiety	___ Head-banging	___ Poor appetite	___ Panic attacks
___ Sexual acting out	___Hopelessness	___Bed wetting	___Running away
___ Excessive masturbation	_____Hurts animals	___Sick often	___Blinking/jerking
___ Imaginary friends	___Short attention span	___Bizarre behavior	_____Impulsive
___ Shy, timid	___ Bullies, threatens	___ Irritable	___ sleeping problems
___ Careless, reckless	___Lazy	___ Slow moving	___ Lies frequently

___ Learning problems ___Soiling ___ Clumsy ___ Steals
___ Speech problems ___Trouble with authority ___Listens to reason____Chest pain
___ Skin picking/scratching____Stomach-aches ___Cyber addiction ___Low self-esteem
___ Suicidal threats ___Defiant ___ Suicide attempts ___ Depression
___ Moody ___ Talks back ___ Nightmares ___ Phobias
___ Sibling problems ___Gang involvement ___Thumb-sucking ___Dizziness
___ Tics or twitching ___Oppositional ___ Eating disorders ___ withdrawn
___ Over-active ___ Over-weight ___ Weight loss ___ Worries
___ Other behavioral concerns:_____

_____

_____

Developmental History

Please indicate if any of the below events were "normal" or "abnormal." Please describe any significant event.

Physical:

- Pregnancy, delivery, feeding, sleeping pattern, weaning, neonatal illnesses:

  _____

  _____
- Neuromuscular development of speech, motor milestones (sitting, standing, walking, first words, play) _____

  _____

Behavioral:

- Toilet training and other training-response to discipline and methods used: _____

  _____
- Reactions to beginning daycare or school: _____
- Phobias/ recurring fears: _____
- Habits/ repeated issues (bedwetting, hair pulling, picking, thumb-sucking): _____

  _____

Social Adjustment

- Age appropriate peer relationships: _____
- Age appropriate social etiquette: _____
- Age appropriate involvement in organized groups: _____

  _____

Stressors Related to the Child

Please identify if any of the following are a current or past stressor for your child. Please indicate approximate age at the time the stressor occurred and a brief description.

___ Chronic illness of a family member: _____
___ Family member absent: _____
___ Family members disability/major accident: _____
___ Family members emotional problems: _____
___ Family members suicide: _____

___ Family members in psychiatric treatment:___If yes please explain: _____

_____

___ Parents divorce: _____

___ Death of a pet: _____

___ Sexual assault: _____

___ Other traumatic experiences: _____

_____

Your Concerns

What concerns do you have about your child? _____

_____

_____

How long have these concerns existed? _____

Have others expressed concerns about your child? _____

What do you think might be causing this? _____

_____

How have you tried to address your concerns? _____

_____

What have you done to cope with or resolve these issues? _____

_____

Have any of these interventions been helpful: ___ Yes ___ No

Describe your child's personality _____

_____

What are some of your child's coping skills? _____

_____

Does your child have friends or activities that you don't approve of? If yes, please explain.

_____

_____

Describe your relationship with your child _____

_____

What are your child's strengths? _____

What would you like to change about the situation? _____

_____

What are you hoping to achieve in counseling?
1. _____ 2. _____

3. _____ 4. _____

Any additional comments or concerns _____

_____

_____

_____

By signing below, I confirm that the above information is true and correct. I understand that I must be committed to attend sessions on a consistent basis in order to receive the greatest benefit from therapy. Although I may stop therapy at any time, I agree to inform my therapist of my decision prior to my last visit. If my therapist believes that I can receive more effective treatment elsewhere, I will be given referrals. I understand that I may not attend a session if I am under the influence of alcohol or drugs, or if I am in possession of a dangerous weapon. I understand that I have the right to agree to, or to refuse mental health services provided by Dr. Mahnaz Sadre Ph. D., LMFT-S, LPC-S.

My signature below indicates that I am the legal parent/guardian and I have the right to consent to mental health treatment. My signature below indicates my desire and consent for my child, _____ to receive mental health services from Dr. Mahnaz Sadre at
Child's name

Life Solutions: Family Counseling and Coaching Center.

_____
Printed name of client

_____ _____
Signature of Party financially responsible/Parent/Guardian Date

_____ _____
Therapist's signature Date