Oaktree Counseling
Nikki Schwartz, MA, LPC, NCC
Licensed Professional Counselor

New Client Form (Child)

Date

Instructions: Please complete this form to the best of your ability with the information you have available to you at this time. Do your best to answer each item as fully as you can.

General Client Information

Name: First, Middle, Last Gender: ☐ M ☐ F Age: DOB:

Name of Client's School: Grade: Handedness: ☐ R ☐ L

Current Issues

Please provide a brief description of why you are seeking counseling &/or neurofeedback services for your child at this time:

Has anything happened that may have brought on/intensified the problems your child is experiencing? ☐ Yes ☐ No
If yes, please explain:

- When (month/year) did your child first begin to experience these problems?
- How many days, weeks, months, or years has your child been experiencing these problems?
- How often does your child experience these problems? (check the one that best describes his/her current experience).
  - ☐ Most of the day, every day
  - ☐ Some part of the day, every day
  - ☐ Most of the day on most days
  - ☐ Some part of the day on most Days
  - ☐ More than once a week
  - ☐ More than once a month
  - ☐ Other
- How much is/are the problems affecting your child? ☐ Mildly ☐ Moderately ☐ Severely
- In what areas do your child's problems impact his/her life? (Check all that apply)
  - ☐ Lifestyle (the way your child lives his/her life)
  - ☐ Activities (things your child would normally do or would like to do)
  - ☐ Relationships (your child's ability to form or maintain relationships with others)
  - ☐ Eating ☐ Sleeping ☐ Mood
- Has your child ever attempted suicide? ☐ Yes ☐ No If yes, when?
- Has your child been thinking about suicide? ☐ Yes ☐ No
- Has your child ever thought about harming or killing someone else? ☐ Yes ☐ No If yes, when?
- Has your child been thinking about harming or killing someone else? ☐ Yes ☐ No

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Child Problems Checklist

Instructions: Please check all that apply to you

- ☐ *Abuse or Neglect of Child*
- ☐ *Depression*
- ☐ *Low energy*
- ☐ *Low self-esteem*
- ☐ *Poor concentration*
- ☐ *Lack of interest/enjoyment in life*
- ☐ *Lack of motivation*
- ☐ *Feeling hopeless*
- ☐ *Feeling worthless*
- ☐ *Feeling guilty or shameful*
- ☐ *Sleep changes (more/less)*
- ☐ *Loneliness*
- ☐ *Bad dreams/nightmares*
- ☐ *Feeling Ignored or abandoned*
- ☐ *Appetite changes (more/less)*
- ☐ *Mood swings*
- ☐ *Thoughts of hurting self*
- ☐ *Thoughts of hurting others*
- ☐ *Isolating from others*
- ☐ *Feelings of sadness/loss*
- ☐ *Weight problems*
- ☐ *Stress*
- ☐ *Anxiety/tension/worry*
- ☐ *Panic attacks*
- ☐ *Heart racing*
- ☐ *Chest pain or heaviness*
- ☐ *Chills/hot flashes*
- ☐ *Tingling/numbness*
- ☐ *Muscle twitches*
- ☐ *Pain*
- ☐ *Fear of dying*
- ☐ *Fear of going "crazy"*
- ☐ *Nausea*
- ☐ *Fears or phobias*
- ☐ *Obsessions/compulsions*
- ☐ *Thoughts racing*
- ☐ *Disorganization*
- ☐ *Procrastination*
- ☐ *Can't hold onto an idea*
- ☐ *Anger/frustration*
- ☐ *Suspiciousness*
- ☐ *Mistrustfulness*
- ☐ *Problems trusting others*
- ☐ *Easily irritated/annoyed*
- ☐ *Aggressiveness*
- ☐ *Perfectionist behavior*
- ☐ *Lying*
- ☐ *Making/keeping friends*
- ☐ *Arguing with others*
- ☐ *Performing unusual rituals or habits*
- ☐ *Impulsiveness*
- ☐ *Delusions/hallucinations (Thinking/believing or seeing/hearing unusual things)*
- ☐ *Sexual problems*
- ☐ *Poor attention*
- ☐ *Completing tasks*
- ☐ *Staying on task*
- ☐ *Hyperactivity*
- ☐ *Difficulty sitting still*
- ☐ *Fidgeting*
- ☐ *Clumsiness*
- ☐ *Excessive talking*
- ☐ *Poor organization*
- ☐ *Poor time management*
- ☐ *Procrastination*
- ☐ *Sensory sensitivities*
- ☐ *Sensory deficits*
- ☐ *Auditory*
- ☐ *Hypersensitivity*
- ☐ *Auditory deficits*
- ☐ *Visual hypersensitivity*
- ☐ *Visual Deficits*
- ☐ *Tinnitus (ears ringing)*
- ☐ *Poor body awareness*
- ☐ *Shyness*
- ☐ *Lack of social support, family/friends*
- ☐ *Poor social skills*
- ☐ *Autism*
- ☐ *Lack of eye contact*
- ☐ *Poor social/emotional reciprocity*
- ☐ *Poor emotional awareness*
- ☐ *Poor speech articulation*
- ☐ *Echolalia*
- ☐ *Lack of social interest*
- ☐ *Lack of social awareness*
- ☐ *Motor/vocal tics*
- ☐ *Poor empathy*
- ☐ *Stuttering*
- ☐ *Difficult to soothe*
- ☐ *Easily embarrassed*
- ☐ *Emotionally reactive*
- ☐ *Self-Injurious Behavior*
- ☐ *Pulling out hair, fingernails, eyelashes, or eyebrows*
- ☐ *Picking at skin or scabs*
- ☐ *Oppositional or Defiant*
- ☐ *Stealing*
- ☐ *Strange, weird, or peculiar behavior*
- ☐ *Confusion/Can't think clearly*
- ☐ *Feeling "not real"*
- ☐ *Feeling detached from yourself*
- ☐ *Feeling "hyper"*
- ☐ *Physical illness*
- ☐ *Allergies*
- ☐ *Asthma*
- ☐ *Walking or moving*
- ☐ *Fatigue*
- ☐ *Irritable bowel syndrome*
- ☐ *Low muscle tone*
- ☐ *Muscle weakness*
- ☐ *Poor motor coordination*
- ☐ *Poor balance*
- ☐ *Heart palpitations*
- ☐ *High blood pressure*
- ☐ *Tachycardia*
- ☐ *Immune Deficiency*
- ☐ *Sugar craving/reactivity*
- ☐ *Food sensitivities*
- ☐ *Chronic pain*
- ☐ *Fibromyalgia/CFS*
- ☐ *TMJ or jaw pain*
- ☐ *Migraine headaches*
- ☐ *Tension headaches*
- ☐ *Sinus headaches*
- ☐ *Sciatica*
- ☐ *Abdominal Pain*
- ☐ *Health problems*
- ☐ *Losing track of time*
- ☐ *Problems with memory*
- ☐ *Unpleasant thoughts that won't go away*
- ☐ *Bothered by recurring thoughts*
- ☐ *Destruction of property*
- ☐ *Self-criticism*
- ☐ *Family problems*
- ☐ *Problems with boyfriends/girlfriends*
- ☐ *Parent/child problems*
- ☐ *Use of alcohol*
- ☐ *Use of drugs*
- ☐ *Blackouts*
- ☐ *Physical abuse*
- ☐ *Sexual abuse*
- ☐ *Partner abuse*
- ☐ *Trouble with the law*
- ☐ *Experienced/witnessed trauma*
- ☐ *Loss/death of someone close*
- ☐ *Other (please describe below)*

Other, please describe:

Current Life Experiences

My child and I live in: ☐ Apartment ☐ House ☐ Condo/Townhouse ☐ Mobile Home ☐ Rooming House ☐ Other

My child and I live with:

Name	Age	Relationship to child	Problems

Parent/Guardian's Occupation(s): Father Mother

Other significant persons your child's life who do not live in the home include:

Name	Age	Relationship to child	Problems/Resides where?

Problems or changes in family or child's other important interpersonal relationships:

Date(s)	Persons Involved	Relationship to child	Problems or Changes

Problems or changes in occupational, educational, social, or recreational functioning:

Date(s)	Problems or Changes

What activities does your child like doing?

What is most stressful for your child?

What does your child do to relax?

What goals does your child have/do you have for your child for this year?

What do you hope your child will gain from counseling?

My child's typical day is as follows: (attach extra sheets, if necessary)

Current Life Experiences

What are your child's favorite school subject?

What are your child's least favorite subject?

Describe your child's abilities concerning verbal expression and vocabulary.

Describe your child's interest, abilities, and performance in each of the following areas:

Reading

Math

Writing

Penmanship

Art

Spatial Skills

Memory

Homework

What do teacher's usually offer praise to your child for? What, if any, complaints do teachers have? Please list any other important academic information as well.

History of Counseling or /Therapy

Is your child **currently** being treated by a counselor, psychologist, psychiatrist, and/or other physician for the problems noted above? ☐ Yes ☐ No If yes, please provide the following information:

Date(s)	Name of Professional/Address	Treatment Type (counseling, therapy, medication, etc.)

Please provide information regarding **previous** treatment your child has received from a counselor, psychologist, psychiatrist, or other medical or mental health professional for this or other problems:

Date(s)	Name of Professional/Address	Treatment Type/Why treatment ended

Has your child ever been hospitalized for treatment of an emotional or mental disorder? ☐ Yes ☐ No
If yes, please provide the following information:

Date(s)	Name of Hospital or Facility/Address	Reason for Hospitalization

Medical History

Please complete the information below regarding your child's **past and current** medical conditions and treatment:

Date(s)	Physician Name / Address	Condition/Treatment/Results

Medical History Continued

Please list any allergies/sensitivities/drug reactions your child has:

Please list all **current** prescription and over the counter medication use:

Beginning (date)	**Medication/Dose/Frequency of use**	**Condition Treated**

Please list any **previous** prescription and over the counter medication use significant to your counseling/therapy:

Date(s)				**Medication/Dose/Frequency of use**	**Condition Treated**
From		To			
From		To			
From		To			
From		To			

Please list any **current or previous** use of street drugs, tobacco products, or alcohol:

Date(s)				**Type Used/Frequency of Use/Amount Typically Used**	**When ended (if applicable)**
From		To			
From		To			
From		To			

Please list any hospitalizations or surgeries:

Date(s)	**Hospital/Facility**	**Physician**	**Condition/Type Treatment/Surgery**

Medical & Neurological Checklist Neurofeedback Clients ONLY

Has your child *ever* had issues, problems, or concerns with any of the following? check all that apply to your child:

- ☐ *Difficulty falling asleep*
- ☐ *Staying asleep*
- ☐ *Waking up in the morning*
- ☐ *Restless sleep*
- ☐ *Sleepwalking*
- ☐ *Severe &/or freq. nightmares*
- ☐ *Other Sleep Issues*
- ☐ *Allergies*
- ☐ *Asthma*
- ☐ *Frequent Illness*
- ☐ *Fatigue*
- ☐ *Chronic Pain*
- ☐ *Skin Problems*
- ☐ *Eczema*
- ☐ *Psoriasis*
- ☐ *Hypertension*
- ☐ *Palpitations or Tachycardia*
- ☐ *Hearing problems*
- ☐ *Ringing in the ears*
- ☐ *Earaches*
- ☐ *Problems with sense of smell*
- ☐ *Vision problems*
- ☐ *Double or blurred vision*
- ☐ *Blind spots*
- ☐ *Eye pain*
- ☐ *Visual sensitivity*
- ☐ *Seeing shadows*
- ☐ *Digestive or Endocrine problems*
- ☐ *Thyroid*
  - ☐ *high* ☐ *low* ☐ *abnorm*
- ☐ *Heat or cold sensitivity*
- ☐ *Diabetes*
- ☐ *Sugar sensitivity*
- ☐ *Stomach Pain*
- ☐ *Intestinal Pain*
- ☐ *Irritable Bowel Syndrome*
- ☐ *Chronic Constipation*
- ☐ *Nausea or vomiting (unrelated to virus/flu)*
- ☐ *PMS*
- ☐ *Menopausal symptoms*
- ☐ *Headaches*
- ☐ *Migraines*
- ☐ *Fainting*
- ☐ *Seizures*
- ☐ *Poor coordination*
- ☐ *Chronic aching pain*
- ☐ *Chronic nerve pain (burning or stabbing)*
- ☐ *Chronic pain or stiffness*
- ☐ *Tremor or spasticity*
- ☐ *Physically over or under active*
- ☐ *Accident Prone*
- ☐ *Motor or vocal tics*
- ☐ *Other speech problems or impediments*
- ☐ *Low pain threshold*
- ☐ *High pain tolerance*
- ☐ *Prenatal stress or injury*
- ☐ *Premature or late birth*
- ☐ *Prenatal drug exposure*
- ☐ *Difficult birth or labor*
- ☐ *Colic*
- ☐ *Delays in motor development*
- ☐ *Sleep problems*
- ☐ *Eating problems*
- ☐ *Difficult emotional attachment to caregivers*
- ☐ *Delayed emotional development*
- ☐ *Physical injury/trauma*
- ☐ *Head injury w/o loss of consciousness*
- ☐ *Head injury w/ loss of consciousness*
- ☐ *Accidents*
- ☐ *High Fever*
- ☐ *Central Nervous System Infect ion*
- ☐ *Drug overdose*
- ☐ *Poisoning*
- ☐ *Anoxia (lack of oxygen)*
- ☐ *Stroke*
- ☐ *Psychological trauma*
- ☐ *Abuse or neglect*
- ☐ *Death in family*
- ☐ *Illness in family*
- ☐ *Excessive or extreme family stress*
- ☐ *Excessive school or job stress*
- ☐ *Other (please describe):*

Family History for Neurofeedback Clients Only

Has anyone in your family, **(parents, siblings, maternal/paternal, aunts, uncles, grandparents)** *ever* experienced any of the following:

- ☐ *Asthma*
- ☐ *Autoimmune Disorders*
- ☐ *Type I Diabetes*
- ☐ *Rheumatoid Arthritis (RA)*
- ☐ *Lupus*
- ☐ *MS*
- ☐ *Other Autoimmune Disorders*
- ☐ *Thyroid Disorder*
- ☐ *Migraines*
- ☐ *Sleep problems*
- ☐ *Depression*
- ☐ *Bipolar or Manic Depression*
- ☐ *Anxiety*
- ☐ *Phobias*
- ☐ *Panic Attacks*
- ☐ *Motor or Vocal Tics*
- ☐ *Seizuress*
- ☐ *Eating Disorders*
- ☐ *Obesity*
- ☐ *Addictions*
- ☐ *Obsessive Compulsive Symptoms*
- ☐ *Speech Problems*
- ☐ *Attention Problems*
- ☐ *Hyperactivity*
- ☐ *Learning Problems*
- ☐ *Conduct Problems or Criminal Behavior*
- ☐ *Autistic Spectrum Disorders*
- ☐ *Schizophrenia*

If you answered yes to any of the above, please list the issue and the child's relationship to the family member

Issue	**Family Member(s)**

Family of Origin

Please list the members of your child's family of origin in the order that they were born. Include current ages.

Example: Maternal grandmother (deceased), Mother (age 50), father (age 49), sister Anne (age 29), brother Larry (age 27), me (age 24) lived in the childhood home.

Please describe the background or status of your child's family of origin for the following categories:

Ethnic

Religious:

Social:

Financial:

Briefly describe any of the following that apply to your child's family of origin:

Crisis or other significant events:

Any emotional, psychological, or physical illness:

(Examples: cancer, diabetes, heart disease, depression, alcoholism, drug abuse or addiction, family violence, depression, suicide)

Parenting styles of the child's mother, father, and other caretakers? Who does what and how?

Communication styles of the child's family of origin? Who does most of the talking, teaching, and connecting?

Your child's past relationships with his/her:

Mother:

Father:

Stepparent:

Siblings:

Other significant family members:

Your child's current relationship with his/her:

Mother:

Father:

Stepparent:

Siblings:

Other significant family members:

His/Her friends:

Other significant persons:

Developmental History

Briefly describe your child's (1) **physical**, (2) **psychological**, (3) **emotional**, (4) **intellectual**, (5) **social**, (6) **spiritual**, and (6) **academic development**, and (7) **any significant experiences** affecting him/her during the following stages of their life (attach extra sheets, if needed):

Prenatal development and infancy (conception up to age 2):

Early Childhood (age 2 through age 5):

Middle and Late childhood (age 6 through age 11):

Parent/Guardian's Signature: _____ *Date:* _____