Susan Ward, MA, LMFT, CMHS
Child, Couple and Family Therapist
1900 Dock Place, Suite 7
Seattle, Washington 98107

Initial Child Treatment Questions

Child's Name:____Date of Birth:_____________________

Parent/Legal Guardian:____

Address:____

Day Phone: _____________________________ Okay to call/leave message: Yes No

Evening Phone: ________________________________ Okay to call/leave message: Yes No

Other Involved Adult(s): _______________________________Relationship:_____________________

Will they be involved in treatment?____

In order to protect your privacy, I do not identify myself as a counselor when I call. I attempt to return phone calls within 24 hours of receiving them. If you have not heard back from me in a reasonable time, please attempt to call me again.

Introductory Questions

How did you hear about my counseling service? ____

____

Did someone suggest that your child come to see me? ____

May I call the person who told you about me and thank them for the referral? Yes No

Briefly describe the concern(s) that brought you here: ____

____

____

What do you hope to achieve through therapy?____

____

____

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Please tell me about your child's strengths ____

____

____

____

Please tell me about your child's interests ____

____

____

____

Child's History

Current School ______________________________Current Grade ______________

Previous Schools, if any ____

Are there any concerns regarding school or school performance? ______________________________

____

____

Has child always lived with you? ____

____

____

Are there other children in the home? Have there ever been other children in the home? ______________________

____

____

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Current medical problems____
____
____

Any hospitalizations? (please include dates) ____
____
____

Please list any current medications (including herbal)

Name of medication	Start Date	Dosage	Comments

Please list any medications your child has been on in the past for mental health issues

Name of medication	Start Date	Stop Date	Dosage	Comments

Has your child previously seen a therapist? __________ Who/Where? ____________________________

How long ago/for how long? _______________________ For what types of issues? ____
____
____

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What was effective about that treatment? ____

____

____

What about that treatment didn't work? ____

____

____

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Behavior Checklist

	Yes	No	Comments
My child sleeps well			
My child has meaningful friendships			
My child is engaged with school			
My child participates in extracurricular activities			
My child displays acts of self-harm			
My child can be aggressive towards peers			
My child can be aggressive towards adults			
My child argues a lot			
My child has excessive fears			
My child often has physical aches or pains			
My child responds well to discipline			
My child appears nervous			
My child lies to avoid responsibility			
My child takes things that are not his/hers			
My child struggles with maintaining attention			
My child shows interest in learning new things			

Please share any other concerns you have regarding your child's behavior ____

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____

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