CHRISTIAN PSYCHOLOGICAL SERVICES
CONFIDENTIAL

PARENT'S INFORMATION AND APPRAISAL FORM

Name of Child_____ Birthdate_____ Age _____ Gender: M / F

Address_____ City_____State_____ Zip_____

Phone: (_____) _____ Grade_____

Is this the above address where billing should be sent? ____Yes ____No If not, where? _____

School _____ School Address _____ School Phone # _____

Adopted Child ___Yes ____ No At what age? ____ Medical /Social History of birth parents: ___Known ___Unknown

Who has legal custody? _____

PARENT INFORMATION

(Circle one)
Biological/Adoptive Mother _____ Date of Birth _____ SS#_____
Address _____ Home Phone _____
Employer_____ Work Phone_____

(Circle one)
Biological/Adoptive Father _____ Date of Birth _____ SS#_____
Address _____ Home Phone _____
Employer_____ Work Phone_____

Step-Mother _____ Date of Birth _____ SS#_____
Address _____ Home Phone _____
Employer_____ Work Phone_____

Step-Father _____ Date of Birth _____ SS#_____
Address _____ Home Phone _____
Employer_____ Work Phone_____

Religious preference_____ Referred by: *(circle one)* pastor, attorney, physician, relative, former/other client, friend, Yellow Pages, other _____
Name of Referring Person/Party _____
Name of Referring Church, if applicable _____
Phone # of Referring Party _____ Comments_____

(This section to be completed by the counselor only)
Date first seen_____ Counseling fee_____
DSM #_____ Therapist_____

Marital status of the biological/adoptive parents of the child (*check all that apply):*

	Married		Living together		Mother remarried
	Not Married		Separated		Father remarried
	One parent deceased		Divorced		Other_____

Please list all of your children, living and deceased, in the order of their birth

Name	**Age**	**Birthday**	**Gender**	**School**	**Grade in School**	**Lives at Home?**

PROBLEM INFORMATION

Briefly describe your primary concern about your child_____
_____
_____

Briefly describe the history and development of your concern from onset to present_____
_____
_____
_____
_____

Please identify any specific concerns or anxieties you have about counseling for the child_____
_____
_____

What are your goals for this counseling? (*be as specific as you can*)_____
_____
_____

What is the child's understanding of and attitude toward this counseling? (*please be specific*)_____
_____
_____

Previous experience with counseling: _____No _____Yes When_____
By whom_____
How helpful was previous counseling?_____
_____

Mother's health during pregnancy: _____unknown _____ good _____some difficulty _____ many difficulties

	Anemia		**Bleeding**		**Nausea and vomiting**
	Diseases		**Urine problems**		**Toxemia**
	Poor diet		**Blood pressure**		**Headaches**
	Accidents		**Weight problems**		**Other ***

***Other**_____

Medication/drugs taken (specify) _____

Length of labor _____ hours Forceps used? _____Yes ____ No Birth weight _____

Problems/complications during or after delivery: _____

Number of lost pregnancies_____

Who, other than the mother, was involved in caring for the child during infancy to five years? _____

_____

Record CAREFULLY the age at which the child accomplished each of the following:

	Sat alone		**Walked alone**		**Toilet trained**
	Crawled		**Said words**		**Rode bicycle (2-wheeler)**
	Stood alone		**Used sentences**		

Does your child have a history of or current problem in any of the following areas?

	Eating Problems		**Bed Wetting**		**Masturbation**
	Sleep Difficulties		**Wetting Pants**		**Runaway**
	Speech Difficulties		**Soiling Pants**		**Truancy**
	High Temperatures		**Constipation**		**Distractible**
	Head Injuries		**Headaches**		**Temper Tantrums**
	Other Serious Injury*		**Hospitalizations**		**Social Withdrawal**

* Please explain: _____

Please list any serious illnesses/medical problems that the child has had and give approximate dates: _____

_____

_____

List any hospitalizations (*reasons/diagnoses/dates*):_____

_____

Date of child's most recent physical examination _____

List any medications your child is taking at the present time:

MEDICATION	**REASON PRESCRIBED**	**DOSE & FREQUENCY**	**DATE STARTED**	**PRESCRIBING PHYSICIAN**

Please identify any family history of:

	Alcoholism		**Retardation**		**Learning problems**
	Drug abuse		**Emotional problems**		**Over-activity**
	Suicide		**Marital problems**		**Bipolar Disorder (Manic Depression)**
	Suicide attempts		**Depression**		**Physical or Sexual Abuse**

Other: _____

Do any family members have any special medical problems? _____No _____ Yes
If yes, please explain:_____

Is there a history of similar problems with family members or relatives? **(*please describe*)**_____
_____

Have the child's report cards or school conferences indicated any special difficulties?
_____ Class work _____ Behavior_____ Attitude

Please describe: _____

_____

_____

What grades has your child repeated (if applicable)?_____

Check any of the following that definitely describe your child:

	Selfish		**Impulsive/acts without thinking**		**Sexual difficulties**		**Emotional**
	Resentful		**Quick tempered**		**Resents authority**		**Obedient**
	Seclusive		**Problems concentrating**		**Unmotivated**		**Silliness**
	Quarrelsome		**Violent**		**Spoiled**		**Sensitive**
	Doesn't care		**Inconsiderate**		**Untidy**		**Considerate**
	Easily Led		**Ill tempered**		**Adaptable**		**Inadequate**
	Untruthful		**Impertinent, Sassy**		**Unruly**		**Moody**
	Won't obey		**Affectionate**		**Cruel**		**Vain**
	Awkward		**Industrious**		**Clean**		**Stubborn**

As legal guardian/custodial parent of the child listed above, do you give permission for him/her to engage in counseling/assessment at Christian Psychological Services? _____

For children of divorced parents, please provide a copy of your custody agreement.

Is the information you have provided on this form true and accurate? _____

_____ _____
Signature **Date**