MID-VALLEY COUNSELING CENTER
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SALEM, OREGON 97301
503-364-6093

Please bring this completed form with you at the time of your child's first appointment.

Person completing form: _____
Relationship to child: _____
Child's name: _____ DOB: _____ Age: ____ Sex: ___
Child's school: _____ Grade: _____

Present placement of child (place check in appropriate box):

	Column A Adults with whom Child is living	Column B Non-residential adult Involved with child
Natural Mother	[ ] _____	[ ] _____
Natural Father	[ ] _____	[ ] _____
Stepmother	[ ] _____	[ ] _____
Stepfather	[ ] _____	[ ] _____
Adoptive Mother	[ ] _____	[ ] _____
Adoptive Father	[ ] _____	[ ] _____
Foster Mother	[ ] _____	[ ] _____
Foster Father	[ ] _____	[ ] _____
Other (specify)	[ ] _____	[ ] _____

Place the number 1 or 2 next to each check in Column A and provide the following information about each person:

1) Name _____ Occupation: _____
   Business Name: _____
   Business Address: _____
   Business Ph. No: _____ Home Ph. No: _____

2) Name _____ Occupation: _____
   Business Name: _____
   Business Address: _____
   Business Ph. No: _____ Home Ph. No: _____

Place a number 3 next to the person checked in Column B who is most involved with the child and provide the following information:

1) Name _____ Occupation: _____
   Business Name: _____
   Business Address: _____
   Business Ph. No: _____ Home Ph. No: _____

Referred by: _____
Family physician: _____
Address: _____
Phone No: _____ Fax No: _____

Purpose of Consultation *(brief summary of the main problems)*:

PREGNANCY:
Complications: *(Check any that apply.)*
___ Excessive vomiting Hospitalization required? Y N If yes, how long? _____
___ Excessive staining or blood loss
___ Threatened miscarriage?
___ Infection(s)? If so, specify: _____
___ Toxemia
___ Operation(s)? If so, specify: _____
___ Other illness(es)? If so, specify: _____

Smoking during pregnancy:
Y N Average number of cigarettes per day ____

Alcoholic consumption during pregnancy:
Y N Describe if beyond an occasional drink _____

Medications taken during pregnancy: *(Please list.)*

DEVELOPMENTAL HISTORY: Describe and/or remark about the early development of your child. If the area does not apply, leave it blank. If your child entered your family through adoption, foster care, etc., please provide any information regarding pregnancy, birth or early parenting, if known.

(If applicable, please note on a separate piece of paper if the child entered the family through adoption, at what age, has this been shared with the child? If so, how? What was the response? Are any siblings adopted?)

Delivery:

1. Was baby born at expected time? Y N Birth weight: _____
   Length _____ Do you know head circumference? _____
2. Length of labor _____
3. Was labor spontaneous or induced? _____
4. Were forceps used? ____ High ____ Mid ____ Low
5. Normal or breech at delivery? _____
6. Caesarisn Section? Y N If yes, why? _____
7. What type of anesthesia (if any) was used? _____
8. Did baby cry immediately? Y N If not, what was response? _____
9. Any marks on face, head, etc.? _____
10. Anything unusual, such as cord around neck? _____
    Cord presented first? Y N Hemorrhage? Y N

Post-Delivery Period: (while in hospital)

Respiration: ____ Immediate ____ Delayed (if so, how long? _____)
Cry: ____Immediate ____ Delayed (if so, how long? _____)
Mucus accumulation: Y N
Apgar Score (if known): ____ Jaundice: Y N Cyanosis (turned blue): Y N
Rh factor: Y N Transfusion? Y N
Incubator care? Y N Number of days: _____
Suck: ____ Strong ____ Weak Diarrhea? Y N Vomiting? Y N
Infection (specify): _____
Birth defects (specify): _____
Total number of days baby was in hospital after delivery: _____

Infancy-Toddler Period:

Were any of the following present – to a significant degree – during the first few years of life?

Y N Did not enjoy cuddling
Y N Was not calmed by being held and/or stroked
Y N Colic
Y N Excessive restlessness
Y N Diminished sleep because of restlessness and easy arousal.
Y N Frequent headbanging
Y N Constantly into everything
Y N Excessive number of accidents compared to other children

DEVELOPMENTAL MILESTONES:

If you can recall, record the age at which your child reached the following developmental milestones. If you cannot recall age, check appropriate box at right.

Developmental Milestone	Age	I cannot recall exactly, but to the best of my recollection, it occurred Early	Normal time	Late
Smiled				
Sat without support				
Crawled				
Stood without support				
Walked without assistance				
Spoke first words besides “mama” and “dada”				
Said phrases				
Said sentences				
Bowel trained, day				
Bowel trained, night				
Bladder trained, day				
Bladder trained, night				
Rode tricycle				
Rode bicycle (without training wheels)				
Buttoned clothing				
Tied shoelaces				
Named colors				
Named coins				
Said alphabet in order				
Began to read				

COORDINATION:

Rate your child on the following skills:

Skill	Good	Average	Poor
Walking			
Running			
Throwing			
Catching			
Shoelace tying			
Buttoning			
Writing			
Athletic abilities			

COMPREHENSION AND UNDERSTANDING:

Do you consider your child to understand directions and situations as well as other children his or her age? Y N If not, why not?

How would you rate your child's overall level of intelligence compared to other children?

____ Below average ____ Average ____ Above average

SCHOOL:

Rate your child's school experiences related to academic learning:

	Good	Average	Poor
Nursery School			
Kindergarten			
Current grade			

To the best of your knowledge, at what grade level is your child functioning in

Reading _____ Spelling _____ Arithmetic _____

Has your child ever had to repeat a grade? If so, when? _____

Present class placement: Regular class Y N Special class Y N (*if yes, specify*):

Kinds of special therapy or remedial work your child is currently receiving:

Describe briefly any academic school problems:

Rate your child's school experience related to behavior:

	Good	Average	Poor
Nursery School			
Kindergarten			
Current grade			

Does your child's teacher describe any of the following as significant classroom problems?

____ Doesn't sit still in his or her seat.
____ Frequently gets up and walks around the classroom.
____ Shouts out. Doesn't wait to be called upon.
____ Won't wait his or her turn.
____ Does not cooperate well in group activities.
____ Typically does better in a one-on-one relationship.
____ Doesn't respect the rights of others.
____ Doesn't pay attention during storytelling.

Describe briefly any <u>other</u> classroom behavioral problems:

PEER RELATIONSHIPS:

Y N Does your child seek friendships with peers?
Y N Is your child sought by peers for friendship?
Y N Does your child pay primarily with children his or her own age?
If no, ____ younger or ____ older?

Describe briefly any problems your child may have with peers:

HOME BEHAVIOR:

All children exhibit, to some degree, the kinds of behavior listed below. Check those that you believe your child exhibits to an excessive or exaggerated degree when compared to other children his or her age.

	Hyperactivity (high activity level		Acts like he or she is driven by a motor
	Poor attention span		Wears out shoes more frequently than siblings
	Impulsivity (poor self control)		Heedless to danger
	Low frustration threshold		Excessive number of accidents
	Temper outbursts		Doesn't learn from experience
	Sloppy table manners		Poor memory
	Interrupts frequently		More active than siblings
	Doesn't listen when being spoken to		Sudden outbursts of physical abuse of other children

INTERESTS AND ACCOMPLISHMENTS:

What are your child's main hobbies and interests?
What are your child's areas of greatest accomplishment?
What does your child enjoy doing most?
What does your child dislike doing most?

MEDICAL HISTORY:
If your child's history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information.

Childhood diseases (describe any complications):
Operations:
Hospitalizations for illness(es) other than operations:
Head injuries: ____ with unconsciousness ____ without unconsciousness
Convulsions: ____ with fever ____ without fever
Coma:

Meningitis or encepthalitis:
Immunization reactions:
Persistent high fevers: Highest temperature ever recorded:
Eye problems:
Ear problems:
Poisoning:
Present medical status:
Present height: Present weight:
Present illness(es for which child is being treated:
Medications child is taking on an ongoing basis:

FAMILY HISTORY – MOTHER:

Current age: _____ Age at time of pregnancy with patient: _____
Number of previous pregnancies: _____
Number of spontaneous abortions (miscarriages): _____
Number of induced abortions: _____
Sterility problems (specify):
School: Highest grade completed Repeated grade: Learning problems? (specify) Behavior problems? (specify) Medical problems? (specify)
List any relatives with a history of mental/emotional problems (including drug/alcohol abuse):

List any blood relatives (not including patient or siblings) that ever had problems similar to those of your child. Beside name, list the problem.
Degree of relative's alcohol/drug use, if any. Please be specific.

FAMILY HISTORY – FATHER:

Current age: _____ Age at time of patient's conception: _____
Sterility problems (specify):
School: Highest grade completed Repeated grade: Learning problems? (specify) Behavior problems? (specify) Medical problems? (specify)
List any relatives with a history of mental/emotional problems (including drug/alcohol abuse):
List any blood relatives (not including patient or siblings) that ever had problems similar to those of your child. Beside name, list the problem.
Degree of relative's alcohol/drug use, if any. Please be specific.

Most children exhibit, at one time or another, one or more of the symptoms listed below. Circle the **P** next to those that your child has exhibited in the **PAST** and circle the **N** next to those that your child exhibits **NOW**. Only mark those symptoms that have been or are present to a significant degree over a period of time. Only check as "problem" if you suspect that behavior is unusual or atypical when compared to what you consider to be normal for your child's age. Then, on page 13, list the symptoms checked off on pages 10-12 and write a <u>brief</u> description including age of onset, duration, and any other pertinent information.

P N	Thumb sucking	P N	Exhibits gestures and intonations of the opposite sex	P N	Excessive demands for attention
P N	Preoccupied with food – what to eat and what not to eat	P N	Frequent temper tantrums	P N	Insomnia (difficulty sleeping)
P N	Frequently likes to wear clothing of the opposite sex	P N	Constipation	P N	Frequent stomach cramps
P N	Baby talk	P N	Excessive silliness and clowning	P N	Cries easily and frequently
P N	Overly dependent for age	P N	Encopresis (soiling)	P N	Enuresis (bed wetting)
P N	Preoccupation with bowel movements	P N	Frequent headaches	P N	Frequent nausea and vomiting
P N	Generally immature	P N	Long periods of dieting and food abstinence with underweight	P N	Bribes other children
P N	Frequent nightmares	P N	Excessive masturbation	P N	Frequent use of profanity to parents, teachers, and other authorities
P N	Often complains of bodily aches and pains	P N	Self-destructive behavior	P N	Not accepted by peer group
P N	Eats non-edible substances	P N	Cruelty to animals	P N	Excessively competitive
P N	Night terrors (terrifying night-time outbursts)	P N	Poor follow-through	P N	Selfish
P N	Worries over bodily illness	P N	Little, if any, response to punishment for anti-social behavior	P N	Often cheats when playing games
P N	Overeating with overweight	P N	Suspicious, distrustful	P N	Truancy from school
P N	Sleepwalking	P N	Low curiosity	P N	Doesn't respect the rights of others
P N	Poor motivation	P N	Aloof	P N	Sore loser
P N	Eating binges with overweight	P N	Open defiance of authority	P N	Runs away from home

P N	Excessive sexual interest and preoccupation	P N	Few, if any, friends	P N	Wants things own way with exaggerated reaction if thwarted
P N	Apathy	P N	Wise-guy or smart-aleck attitude	P N	Doesn't know when to stop
P N	Takes path of least resistance	P N	Blatantly uncooperative	P N	Violent outbursts of rage
P N	Under-eating with under-weight	P N	Doesn't seek friendships	P N	Stealing
P N	Frequent sex play with other children	P N	Brags or boasts	P N	Trouble putting self in other person's position
P N	Ever trying to avoid responsibility	P N	Persistent lying	P N	Rarely sought by peers
P N	Often feels cheated or gypped	P N	Negativistic (does just the opposite of what is requested)	P N	Alcohol abuse
P N	Cruelty to other children	P N	Egocentric (self-Centered)	P N	Very tense
P N	Feels others are perse-cuting him when there is no evidence for such	P N	Little, if any, guilt over behavior that causes others pain & discomfort	P N	Involuntary grunts, vocal-izations (understandable or not)
P N	Criminal and/or dangerous acts	P N	Is often picked on and easily bullied by other children	P N	Excessive modesty over bodily exposure
P N	Destruction of property	P N	Quietly, or often silently, defiant of authority	P N	Nail biting
P N	Frequently hits other children	P N	Anxiety attacks with pal-pations (heart pounding), shortness of breath, sweating, etc.	P N	Chews on clothes, blankets, etc.
P N	Argumentative	P N	Excessive self-criticism	P N	Stuttering
P N	Trouble with the police	P N	Head banging	P N	Depression
P N	Excessively critical of others	P N	Feigns or verbalizes com-pliance or cooperation but doesn't comply with requests	P N	Frequently blames others as a cover-up for own short comings
P N	Typically wants his/her own way	P N	Disorganized	P N	Hair pulling
P N	Violent assault	P N	Feelings easily hurt	P N	Drug abuse
P N	Excessively taunts other children	P N	Very stubborn	P N	Frequent crying spells
P N	Obstructionistic	P N	Tics such as eye-blinking, grimacing, or other spas-modic repetitious movements	P N	Picks on skin

P N	Fire setting	P N	Dissatisfaction with appearance or body	P N	Excessive worrying over minor things
P N	Ever complaining	P N	Speaks rapidly and under pressure	P N	Little concern for personal appearance or hygiene
P N	Suicidal preoccupation, gestures, or attempts	P N	Shy	P N	Gullible and/or naïve
P N	Little concern for or pride in personal property	P N	Excessive guilt over minor indiscretions	P N	Speech non-communicative or poorly communicative
P N	Irritable (easily flies off the handle)	P N	Inhibited self-expression in dancing, singing, laughing, etc.	P N	Inhibits open expression of anger
P N	Excessive desire to please authority	P N	Asks to be punished	P N	Passive and easily led
P N	Gets hooked on certain ideas and remains pre-occupied	P N	Low self-esteem	P N	Hears voices
P N	Too good	P N	Recoils from affectionate physical contact	P N	Allows self to be easily taken advantage of
P N	Often appears insincere and/or artificial	P N	Withdrawn	P N	Excessive fantasizing (lives in his own world)
P N	Compulsive repetition of seemingly meaningless physical acts	P N	Mute (refuses to speak, but can)	P N	Sees visions
P N	Too mature, frequently acts older than actual age	P N	Flat emotional tone	P N	Frequently pouts and/or Sulks
P N	Fears asserting self				

FEARS:

P N	Dark
P N	New situations
P N	Strangers
P N	Being along
P N	Death
P N	Separation from parent
P N	School
P N	Visiting other children's homes
P N	Going away to camp
P N	Animals
P N	Other fears:

Other behaviors that concern you:

As requested above, please first list below symptoms marked with the letter P and next to each symptom give descriptive information such as age on onset, age of termination, and other important data. Then list symptoms marked with an N and provide similar information.

P or N	Symptom	Brief Description

SIBLINGS:

Name	Age	Medical, Social or Academic Problems

LIST NAMES AND ADDRESSES OF ANY OTHER PROFESSIONALS CONSULTED:

Name	Address

ADDITIONAL REMARKS OR COMMENTS YOU WISH TO MAKE REGARDING YOUR CHILD'S DIFFICULTIES:

Thank you for cooperating by supplying the information
I have requested.