WHOLE HEALTH PLUS Child Counseling Application	**Internal Use Only** Today's Date & Time: _____ DSM IV, Axis I Code: _____ Circle Type: I, C, F, G or Assessment Only

Child's Name _____

D.O.B. _____ Year in School_____

Mom's Name: _____ D.O.B. _____
Dad's Name: _____ D.O.B. _____
Address: _____

Preferred phone #:(please indicate if NOT okay to leave messages):_____

E-mail: _____
Emergency contact name & number: _____

_____

Parents circle if: 1) Single 2) Married 3) In relationship 4) Separated 5)Divorced 6) Widowed 7) Re-married

List your child's current medical or psychiatric diagnosis or any recent problems:

_____

List child's current medications or supplements:_____

_____

List any recent or current doctors or therapists providing treatment to your child:

_____

Has your child been exposed to Domestic Violence or been abused?

_____

Has your child had any past or recent suicidal/homicidal thoughts, attempts or plans? _____
If yes, when & what?_____

Has your child had any self-injurious behavior (i.e. cutting, banging) or addictive behavior (i.e. alcohol/drug abuse, gaming, food)? Y/N?
If yes, what and how often: _____

What concerns you about your child? _____
_____

What changes are you hoping to see for your child? _____
_____

What have you tried to do to help your child? _____
_____