KATHERINE NEFF, LCSW
Child & Family Therapy
www.kebneff.com
kebneffcounseling@gmail.com
732-440-8389

PLEASE FILL OUT AS COMPLETELY AS POSSIBLE.

Identifying information:

Child's Name: _____

Address: _____

Date of Birth: _____ Age:_____

Gender: _____

Family Information:

Parent 1: _____ Occupation _____

Best contact #: _____ OK to leave a message at this number? yes no

Parent 2: _____ Occupation _____

Best contact #: _____ OK to leave a message at this number? yes no

Living situation (are parents together? If not, what is the visitation plan?) _____

_____

Is it okay to leave a message at this number? Yes _____ No _____

Siblings (names & ages): _____

_____

Others living in household:_____

_____

Emergency Contact Information:

Name:_____

Phone:_____

Relationship to client or family:_____

Referral Source?: _____

May I thank them? Yes _____ No _____

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School Information:

School: _____ Grade: _____

Does your child receive Special Education Services at school? (if yes, please explain):

_____

_____

Are there any current legal issues or restraining orders related to the client?

Yes_____ No_____ If yes, please explain: _____

_____

Is there a current or past history of involvement with Division of Child Protection & Permanency?

Yes_____ No_____ If yes, please explain: _____

DCP&P Case Manager:_____ phone #:_____

Medical Information:

Pediatrician: _____

Please list any other health care providers involved in your child's care:

_____

_____

Does your child take any medication regularly? (If yes, please list):

_____

Please list any past or current medical conditions including past surgeries or hospitalizations:

_____

_____

_____

Has the client ever been hospitalized for any reason related to mental health?: Yes____ No___

_____

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Has the client been in counseling previously? Yes____ No_____

If yes, please indicate previous counseling services and approximate dates:

_____

_____

In order to better understand the needs of your child, please respond to the following questions:

What are the specific concerns the lead to your bringing your child for therapy?

_____

_____

_____

What are your child's strengths and interests?

_____

_____

_____

Has the client or family experienced any major life changes lately? (circle all that apply)

Move/relocation, change of school, unemployment/financial problems, separation or divorce, catastrophic illness of important person in your lives, death or serious illness of a significant person, or other trauma.

Please explain: _____

_____

Does your child currently exhibit any of the following behaviors? (circle any that apply)

Depression or Sadness, Anger, Frustration, Easily Agitated or Annoyed, Defiant, Poor Self-Esteem, Anxiety or Panic, Bedwetting, Phobias, Aggression, Isolation or Social Withdrawal, Delusions or Hallucinations, Drug and/or Alcohol Use

Please explain: _____

_____

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Has the client ever experienced or engaged in the following behaviors? (circle any that apply)

Reported suicidal thoughts, attempted suicide, engaged in self-injurious behavior (such as cutting), been a victim of or witnessed sexual abuse, been a victim of or witnessed domestic violence

If relevant, please explain below:

_____

_____

Is there any additional information that you feel is important to share at this time?

_____

_____

Responsible Party:

Please complete the following information regarding the person who is financially responsible for this account. (If the client is a minor, the parent bringing the child in for services is considered the responsible party).

Name of responsible party:_____

Relationship to client:_____

Address (if different from address listed above):

_____

City:_____ State:_____ Zip:_____

Thank you for taking the time to complete this form