

TRI-LAKES RELATIONAL CENTER
"Compassionate Christian Care and Counseling"
A ministry of Tri-Lakes Church

CONFIDENTIAL

PARENT'S INFORMATION AND APPRAISAL FORM

Name of Child _____	Birthdate _____	Age _____	Gender: M / F _____
Address _____	City _____	State _____	Zip _____
Phone: (_____) _____	Grade _____		
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

<i>(Circle one)</i>			
Biological/Adoptive Mother _____	Date of Birth _____	SS# _____	
Address _____	Home Phone _____		
Employer _____	Work Phone _____		
<i>(Circle one)</i>			
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 or denominational preference _____	
Referred by: <i>(circle one)</i> pastor, attorney, physician, school official, relative, former/other client, friend, Yellow Pages, other _____	
Name of Referring Person/Party _____	
Name of Referring Church, if applicable _____	
Phone # of Referring Party _____	Comments _____

Do you want to sign a release of information form to waive confidentiality in order for us to contact or consult with the referring party? _____

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

<input type="checkbox"/>	Married	<input type="checkbox"/>	Living together	<input type="checkbox"/>	Mother remarried
<input type="checkbox"/>	Not Married	<input type="checkbox"/>	Separated	<input type="checkbox"/>	Father remarried
<input type="checkbox"/>	One parent deceased	<input type="checkbox"/>	Divorced	<input type="checkbox"/>	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

<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	Nausea and vomiting
<input type="checkbox"/>	Diseases	<input type="checkbox"/>	Urine problems	<input type="checkbox"/>	Toxemia
<input type="checkbox"/>	Poor diet	<input type="checkbox"/>	Blood pressure	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	Accidents	<input type="checkbox"/>	Weight problems	<input type="checkbox"/>	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*) _____

What does your child enjoy doing for fun? _____

Has your child ever been neglected and/or abused? If so, 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? _____

Check any of the following that definitely describe your child:

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

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

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