

Kim E. Lucey, LCSW  
1962 NW Kearney St. Suite 204  
Phone 971-225-0105 Fax 971-200-0699  
[kimluceylcsw@gmail.com](mailto:kimluceylcsw@gmail.com)

Client Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Referred by: \_\_\_\_\_

**\*\*PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY. IF YOUR CHILD IS WILLING AND ABLE, PLEASE COMPLETE THE FORM TOGETHER. IF ANY QUESTIONS ARE NOT CLEAR OR NOT COMFORTABLE, PLEASE FEEL FREE TO LEAVE BLANK AND ASK ANY QUESTIONS.**

CLIENT INFORMATION

Child's Name:

\_\_\_\_\_  
Last First MI Nickname

Address:

\_\_\_\_\_  
Street City State Zip Code Email Address

Telephone: \_\_\_\_\_  
Work Home Cell

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Preferred Pronoun \_\_\_\_\_

School/Grade: \_\_\_\_\_

Parent's Name:

\_\_\_\_\_  
Last First MI

Employer: \_\_\_\_\_ How Long? \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address:

\_\_\_\_\_  
Street City State Zip Code

Parent's Name:

\_\_\_\_\_  
Last First MI

Employer: \_\_\_\_\_ How Long? \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address:

\_\_\_\_\_  
Street City State Zip Code

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Client Name: \_\_\_\_\_

Who will be bringing child to appointments? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

INSURANCE INFORMATION

If your insurance requires prior authorization have you obtained it?  Yes  No

Authorization Code: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip Code

Policy Holder: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Client or authorized person's signature (Required): I authorize the release of any medical or other information necessary to process claim. I authorize payment of medical benefits to the provider of services. I accept responsibility for paying any amount not covered by insurance.

Signed:

\_\_\_\_\_ Date: \_\_\_\_\_

RELATIONSHIP INFORMATION

Please list the names of significant people in your child's life (Please include names, ages, and whether they live with your child):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child had any recent transitions, experienced divorce, new marriage, new siblings or anything else that may have caused recent stress?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe any other relationship or family stressors:

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If the child's parents are divorced or not present, who do they currently live with? What is your child's visitation schedule with parents and siblings?

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What are your child's greatest strengths? \_\_\_\_\_

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#### TREATMENT HISTORY

Has your child ever been in counseling before?  Yes  No

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Dates	Name of Counselor	Phone Number/Ok to contact?
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Dates	Name of Counselor	Phone Number/Ok to contact?
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Dates	Name of Counselor	Phone Number/Ok to contact?
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What has been helpful in counseling in the past?

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What has not been helpful in counseling in the past?

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#### PRESENTING CONCERNS

Describe the concerns/symptoms that have brought you and your child here today:

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Client Name: \_\_\_\_\_

SYMPTOMS

(Check any symptoms that your child is having or has had recently, star the five that are most concerning)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Feeling hopeless                         | <input type="checkbox"/> Extreme sadness                          | <input type="checkbox"/> Depression               |
| <input type="checkbox"/> Extreme happiness                        | <input type="checkbox"/> Feeling stressed                         | <input type="checkbox"/> Low self-esteem          |
| <input type="checkbox"/> Lack of enjoyment of usual activities    | <input type="checkbox"/> Easily irritated                         | <input type="checkbox"/> Excessive worry          |
| <input type="checkbox"/> Seems on edge                            | <input type="checkbox"/> Feeling guilty                           | <input type="checkbox"/> Feeling anxious          |
| <input type="checkbox"/> Fear of situations where escape is hard  | <input type="checkbox"/> Feeling fearful                          | <input type="checkbox"/> Sudden feelings of panic |
| <input type="checkbox"/> Change in sleeping habits                | <input type="checkbox"/> Trouble at work                          | <input type="checkbox"/> Self-starvation          |
| <input type="checkbox"/> Paranoid thoughts                        | <input type="checkbox"/> Procrastination                          | <input type="checkbox"/> Reckless behavior        |
| <input type="checkbox"/> Indecisiveness                           | <input type="checkbox"/> Mind going blank                         | <input type="checkbox"/> Hearing voices           |
| <input type="checkbox"/> Increased use of alcohol or drugs        | <input type="checkbox"/> Avoiding things                          | <input type="checkbox"/> Crying spells            |
| <input type="checkbox"/> Suicidal thoughts or attempts            | <input type="checkbox"/> Statements/Thoughts about hurting others |   |
| <input type="checkbox"/> Statements/thoughts about killing others | <input type="checkbox"/> Acted violently                          | <input type="checkbox"/> School struggles         |
| <input type="checkbox"/> Struggles with anger                     | <input type="checkbox"/> Intrusive thoughts                       | <input type="checkbox"/> Relationship struggles   |
| <input type="checkbox"/> Physical complaints of pain              | <input type="checkbox"/> Chest pain                               | <input type="checkbox"/> Chronic pain             |
| <input type="checkbox"/> Memory problems                          | <input type="checkbox"/> Trouble concentrating                    | <input type="checkbox"/> Low energy               |
| <input type="checkbox"/> Numbness                                 | <input type="checkbox"/> Dry mouth                                | <input type="checkbox"/> Appetite changes         |
| <input type="checkbox"/> Weight changes                           | <input type="checkbox"/> Stomach or bowel issues                  | <input type="checkbox"/> Chronic Weakness         |
| <input type="checkbox"/> Nerve problems                           | <input type="checkbox"/> Trembling                                | <input type="checkbox"/> Startles easily          |
| <input type="checkbox"/> Twitching                                | <input type="checkbox"/> Muscle tension/aches                     | <input type="checkbox"/> Shortness of breath      |
| <input type="checkbox"/> Others not listed: _____                 |   |   |

When did you start noticing your child struggling emotionally or behaviorally? \_\_\_\_\_

Has anyone else reported concerns with your child's emotions or behaviors?  
\_\_\_\_\_  
\_\_\_\_\_

Has your child ever been hurt (physically or sexually) by someone they are close to or involved with, or by a stranger?  Yes  No

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Client Name: \_\_\_\_\_

GOALS FOR TREATMENT

What are the main goals for treatment?      How would you and your child feel successful?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

MEDICAL INFORMATION

Does your child have any current medical struggles?  Yes  No (If yes, please describe)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does our child have any allergies (prescriptions meds, over the counter, other things?)

Yes  No

If yes, what is he/she allergic to and what is their reaction?

\_\_\_\_\_

Who is your child's Primary Care Doctor? \_\_\_\_\_ Phone: \_\_\_\_\_

Has your child seen a doctor in the past year?  Yes  No

Name:              Phone:              Reason for visit:              Diagnosis:              Outcome:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your child taking any medication (Prescription, over the counter or herbal)?  Yes  No

(Please list)

Medication:              Purpose:              Dosage:              Start Date:              Prescriber:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child ever been hospitalized?  Yes  No

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For what reason? \_\_\_\_\_

Location/facility name: \_\_\_\_\_

Has anyone in your family had similar emotional or psychological difficulties or concerns?  
Please explain.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were there any struggles with your pregnancy or child's birth?  Yes  No

Please describe:

\_\_\_\_\_  
\_\_\_\_\_

#### SUBSTANCE USE HISTORY

Has your child ever use tobacco in any form?  Yes  No

(Please describe history, age of first/last use and current pattern of use)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child ever used alcohol?  Yes  No

(Please describe history, age of first/last use and current pattern of use)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child ever used illegal drugs?  Yes  No

(Please describe history, age of first/last use and current pattern of use)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child ever received treatment for substance abuse/use?  Yes  No

Date:            Where:            Did you complete?            Counselors name/phone/may I contact?:

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Client Name: \_\_\_\_\_

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Please describe any family history of substance use/abuse:

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**LEGAL**

(Please check all that apply)

- No legal problems    Parole/probation    Arrest (s) not substance related  
 Arrest (s) substance related    Jail/Prison time

Last legal difficulty (when and what was nature): \_\_\_\_\_

**CULTURAL IDENTITY AND RELIGIOUS/SPIRITUAL PRACTICE**

How would you describe your race or ethnicity?

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Religion/spiritual history: \_\_\_\_\_

Importance of spirituality/religion:  Low    Medium    High

Please describe cultural and spiritual/religious activities or traditions that are important to your family and/or your child:

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Is your child and/or family currently active in your community in other areas?  Yes  No

Please describe: \_\_\_\_\_