Kim E. Lucey, LCSW
1020 SW Taylor St. Suite 700
Portland, OR 97205
Phone 971-225-0105 Fax 971-200-0699
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_____

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Client Name: _____

Employer's Address:

_____

Street City State Zip Code

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?

_____

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Client Name: _____

_____
_____

Describe any other relationship or family stressors:

_____
_____
_____

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?

_____
_____
_____

What are your child's greatest strengths?_____
_____
_____

TREATMENT HISTORY

Has your child ever been in counseling before? □ Yes □ No

_____

Dates	Name of Counselor	Phone Number/Ok to contact?

_____

Dates	Name of Counselor	Phone Number/Ok to contact?

_____

Dates	Name of Counselor	Phone Number/Ok to contact?

What has been helpful in counseling in the past?

_____

What has not been helpful in counseling in the past?

_____

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Client Name: _____

PRESENTING CONCERNS

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

_____
_____
_____
_____

SYMPTOMS

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

□ Feeling hopeless
□ Extreme happiness
□ Lack of enjoyment of usual activities
□ Seems on edge
□ Fear of situations where escape is hard
□ Change in sleeping habits
□ Paranoid thoughts
□ Indecisiveness
□ Increased use of alcohol or drugs
□ Suicidal thoughts or attempts
□ Statements/thoughts about killing others
□ Extreme sadness
□ Feeling stressed
□ Easily irritated
□ Feeling guilty
□ Feeling fearful
□ Trouble at work
□ Procrastination
□ Mind going blank
□ Avoiding things
□ Statements/Thoughts about hurting others
□ Acted violently
□ Depression
□ Low self-esteem
□ Excessive worry
□ Feeling anxious
□ Sudden feelings of panic
□ Self-starvation
□ Reckless behavior
□ Hearing voices
□ Crying spells
□ School struggles
□ Struggles with anger
□ Intrusive thoughts
□ Relationship struggles
□ Physical complaints of pain
□ Chest pain
□ Chronic pain
□ Memory problems
□ Trouble concentrating
□ Low energy
□ Numbness
□ Dry mouth
□ Appetite changes
□ Weight changes
□ Stomach or bowel issues
□ Chronic Weakness
□ Nerve problems
□ Trembling
□ Startles easily
□ Twitching
□ Muscle tension/aches
□ Shortness of breath
□ 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?

_____

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Client Name: _____

_____

_____

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

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)

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Client Name: _____

Medication: Purpose: Dosage: Start Date: Prescriber:

_____
_____
_____
_____

Has your child ever been hospitalized? □ Yes □ No

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)

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Client Name: _____

_____
_____
_____

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

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

_____
_____
_____

Please describe any family history of substance use/abuse:

_____
_____
_____

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?

_____

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:

_____

_____

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

Please describe: _____

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