Internal Strength Counseling, LLC
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Presenting Problem and Treatment History

Please briefly describe why you are seeking counseling for your child:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Medical History:
Please Describe significant medical history:

_____
_____
_____
_____

Please list all prescription, non-prescription medications, and supplements below:

_____
_____
_____
_____
_____
_____

Physician's Name:
_____

Psychiatrist Name: _____

Does your child take all your medications regularly, as prescribed? Y/N. If no, please explain:
_____
_____

Please be aware that outpatient therapy may not be the appropriate level of care for your child at this time based on the severity of what she/he is struggling with. We ask that you be completely honest with us about your symptoms so that we can either offer the best care or refer to a more appropriate level of care.

SYMPTOMS
Please check any symptoms you feel your child is currently experiencing:

- ☐ Often fails to finish things he or she starts
- ☐ Easily distracted
- ☐ Has difficulty concentrating
- ☐ Shifts excessively from one activity to another
- ☐ Frequently is disruptive in class
- ☐ Has difficulty awaiting his/her turn (i.e., games)
- ☐ Has difficulty sitting still
- ☐ Impulsive or acts without thinking
- ☐ Abusive to animals
- ☐ Physically violent towards property (i.e., vandalism, destructive)
- ☐ Physically abusive to self (i.e., scratches self, suicidal attempts)
- ☐ Fire setting
- ☐ Stealing, shoplifting, breaking, and entering
- ☐ Running away
- ☐ Lying
- ☐ Chronic violation of parental limits
- ☐ Drug abuse (what kind?) _____
- ☐ Alcohol abuse (what kind?) _____
- ☐ Any involvement with juvenile court
- ☐ Unrealistic fears (explain)_____
- ☐ Acts too young for his/her age
- ☐ Clings to adults or too dependent
- ☐ Feels no one loves him/her
- ☐ Gets teased a lot
- ☐ Complains of loneliness
- ☐ Demands a lot of attention
- ☐ Easily made jealous
- ☐ Refusal to attend school
- ☐ Avoidance of being left alone
- ☐ Excessive need of reassurance
- ☐ Very self-conscious or easily embarrasses
- ☐ Often appears tense and unable to relax
- ☐ Frequent physical complaints (i.e., headaches, stomach aches, nausea)

- ☐ Overly concerned with future events
- ☐ Nervous mannerisms (i.e., nail biting, thumb sucking, rocking)
- ☐ Feelings of inadequacy
- ☐ Panic – feelings of intense fear/discomfort with palpitations, tremors, shortness of breath, choking feelings, etc.
- ☐ Obsessions – unwanted ideas, images or impulses that intrude on thinking against your wishes and efforts to resist them. (fear of contamination, recurring doubts about danger, extreme concern with order, symmetry, or exactness)
- ☐ Cannot get his/her mind off certain thoughts.
- ☐ Fears he/she may do something bad
- ☐ Fears he/she must be perfect
- ☐ Strange thoughts or ideas (explain)

  _____
- ☐ Hallucinations – visual or auditory (describe)

  _____
- ☐ Inappropriate expression of feelings (i.e., laughing at something sad)
- ☐ Concern that people are out to get him/her
- ☐ Severe mood changes (i.e., very sad to very happy)
- ☐ Often appears sad
- ☐ Confused or seems to be in a fog
- ☐ Daydreams or gets lost in his/her thoughts
- ☐ Doesn't seem to have much energy
- ☐ Social withdrawal
- ☐ Overtired
- ☐ Pessimistic outlook toward the future
- ☐ Excessive tearfulness or crying
- ☐ Recurrent thoughts about death or preoccupation with death
- ☐ Suicidal thoughts or verbalized intentions
- ☐ Concerns about sexual identity
- ☐ Sexually promiscuous
- ☐ Inappropriate sexual behavior (explain)

  _____
  _____
- ☐ Poor relationship with parents
- ☐ Sibling rivalry
- ☐ Negative peer associates – hangs with others that get in trouble
- ☐ Argues a lot, bragging, boasting
- ☐ Mean to others
- ☐ Has difficulty making or keeping friends
- ☐ Does not associate with people his/her own age
- ☐ Avoids unfamiliar social situations
- ☐ Is easily led by others
- ☐ Has difficulty participating in organized activities (sports)
- ☐ Avoid competitive situations
- ☐ Sleep difficulties (i.e., sleepwalking, restless, inability to fall asleep or sleeps too much)
- ☐ Eating difficulties (i.e., has difficulty keeping food down, overeats, does not have much of an appetite, fear of trying new foods, tremendous concern about weight
- ☐ Poor personal hygiene (does not keep self-clean or take an interest in appearance)
- ☐ Enuretic (urinates during the day or night on self)

- ☐ Encopretic (soils self)
- ☐ Deliberately harms self
- ☐ Tics (sudden rapid, recurrent motor movements or vocalizations)

Other symptoms not mentioned above:

_____

How do these symptoms hinder his/her life?

_____

_____

Internet/Electronic Communications Usage

Do you have any concerns with your son or daughter using the internet or electronic communications such as Facebook, Snapchat, Twitter, texting etc.? ___Yes ___No

If yes, please explain your concern:

_____

_____

Please disclose any personal or family history here that you feel will be beneficial for your practitioner to be aware of during your work together.

_____

_____

_____

_____

Please identify goals you would like to achieve while your child is receiving therapy:

1._____

2._____

3._____

Is your child currently suicidal? Yes No

If yes, do they have a plan?
_____

Have they ever had suicidal Thoughts? Yes NO

If yes, When?
_____
_____

Have they ever made a suicide attempt? Yes NO

If yes, When?
_____
_____

Has your son or daughter ever Been diagnosed with a psychiatric disorder?
Yes NO

Provide diagnosis and Explain
_____

Have she/he ever been hospitalized for psychiatric purposes? Yes NO

If yes, When?
_____
_____
_____

Has your child ever Received Therapy? Yes NO

If yes, When?
_____
_____
_____