

MINOR INDIVIDUAL CONCERNS

(Please have every child 8 to 12 years old who will be attending counseling complete this form.)

Name _____ Age _____ Date _____

Do you have trouble with any of the following? Make an **X** by them.

- | | | |
|--|--|---|
| <input type="checkbox"/> Shyness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Trouble with school work |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Trouble remembering | <input type="checkbox"/> Can't concentrate |
| <input type="checkbox"/> Get mad easily | <input type="checkbox"/> Going to sleep | <input type="checkbox"/> Drug use |
| <input type="checkbox"/> Doing things without thinking | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Alcohol use |
| <input type="checkbox"/> Feeling afraid | <input type="checkbox"/> Tiredness | <input type="checkbox"/> Can't have fun |
| <input type="checkbox"/> Being by myself | <input type="checkbox"/> Parent's divorce | <input type="checkbox"/> Problems with parents |
| <input type="checkbox"/> Stomach hurts | <input type="checkbox"/> Separation from parent | <input type="checkbox"/> Problems with friends |
| <input type="checkbox"/> Feeling sad often | <input type="checkbox"/> Making good/right decisions | <input type="checkbox"/> Problems with teachers |

Please list any medications you are taking and their purpose: (prescription and non-prescription)

- | | | |
|--|---------|--------|
| Have you ever thought about hurting yourself or killing yourself? | [] Yes | [] No |
| Have you ever thought about hurting or killing someone else? | [] Yes | [] No |
| Have you ever been hospitalized for a mental health concern? | [] Yes | [] No |
| Have you ever had alcohol to drink? | [] Yes | [] No |
| Have you ever been in trouble with the police? | [] Yes | [] No |
| Have you ever used drugs (marijuana, cocaine, "speed", etc.)? | [] Yes | [] No |
| Are you worried about drug or alcohol use by any one in your family?
If Yes, who? | [] Yes | [] No |

What kinds of problems are you having right now?

What important things about yourself or your family would it be helpful for us to know? (illnesses, handicaps, deaths, divorces, school changes, other)

Do you consider yourself to be a spiritual person? [] Yes [] No

If yes, how do your spiritual beliefs/faith influence your reason for coming to counseling?

When counseling is finished, what do you hope will be different for you?

Thank you for taking time to complete this form. Please be sure to bring it with you to your first appointment. This information is very helpful for your counselor to have as you begin the counseling process.