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.

____ Shyness	____ Headaches	____Trouble with school work
____ Loneliness	____ Trouble remembering	____Can't concentrate
____ Get mad easily	____ Going to sleep	____Drug use
____ Doing things without thinking	____ Nightmares	____Alcohol use
____ Feeling afraid	____ Tiredness	____Can't have fun
____ Being by myself	____ Parent's divorce	____Problems with parents
____ Stomach hurts	____ Separation from parent	____Problems with friends
____ Feeling sad often	____ Making good/right decisions	____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?	[ ] Yes	[ ] No
If Yes, who?		

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.