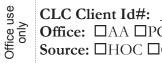
CHESAPEAKE LIFE CENTER COUNSELING INTAKE FORM – FAMILY



Office: □AA □PG □Other _____ Source: □HOC □Community □_____

PAR	ENT / GUARDIAN'S PEI	RSONAL I	NFORMAT	ION
First Name:	Middle Initial:		Last Name: _	
Address:	City:		State:	Zip:
Home Phone:	Work Phone:		Cell Phone: _	
Email Address:				
CHILD'S PERSO	DNAL INFORMATION	List additional	l children receivi	ng services on back)
First Name:	Middle Initial:		Last Name: _	
Age: Birth date:	School:		Grade:	_ Gender: □Male □Female
Who referred you / How did you	1 hear about us:			
	COUNSELING	HISTOR	Y	
Has the child received counseling				
If yes, for what:				
Who counseled/treated the chil	d:	When:	W	as it helpful: □Yes □No
Have any family members ever h	ad counseling?: □Yes □No			
If so, for what: How long:			W	as it helpful: □Yes □No
Is there any family history of drug	g/alcohol abuse?: □Yes □No)		
If so, who:	-		Treatment	was received:
Is there any family history of sexu	lal or physical abuse?: □Yes [∃No		
If so, who?:				_ Treated: □Yes □No
	CHILD'S MEDIC	AL HISTO	RY	
Pediatrician:	Ph	none:		
Pediatrician:	Ph	none:		
Date of child's last physical:				
Does the child have any medical	problems that require treatment	t at this time:	□ Yes □ No	
Please describe:				
Is the child currently taking any p	prescription drugs: \Box Yes \Box N	Jo		
Name:	Dosage:		Purpose:	
Name:	Dosage:		Purpose:	
Name:	Dosage:		Purpose:	
Is the child currently taking any r	non-prescription drugs:	🗆 No		
Name:			Purpose:	
Name:	Dosage:		Purpose:	

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CHILD'S MEDICAL HISTORY (continued)

CHILD'S LOSS HISTORY					

at is the child grieving: _____

For whom or what is the child grieving: ______ Date of Loss: ______

The circumstances leading to the death or separation:

Did the child have the opportunity to say goodbye: □Yes □No □Uncertain

Describe the child's relationship prior to the death:
Loving Distant Distant Over Content Distance Content

CHILD'S CURRENT FUNCTIONING

I have observed the following changes in my child since the death or event occurred: Appetite: □Less than usual □No change □More than usual □Uncertain Sleep Patterns: □Sleeping less than usual □No change □Sleeping more than usual every day □Uncertain Feeling sad or empty: □Never □Occasionally □Frequently □Nearly every day □Constantly Having trouble focusing on schoolwork: □Never □Occasionally □Frequently □Nearly every day □Constantly Diminished ability to think or concentrate or indecisiveness nearly every day: □Yes □No □Uncertain Talks of joining the departed/harming self: □Never □Occasionally □Frequently □Nearly every day □Constantly Behavioral difficulties at school or home: □Never □Occasionally □Frequently □Nearly every day

List additional children receiving counseling

	C	HILD'S PERSONAL INFORM	ATION — Child #2	
First Name: _		Middle Initial:	Last Name:	
Age:	Birth date:	School:	Grade:	Gender: □Male □Female
	C	HILD'S PERSONAL INFORM	ATION — Child #3	i
First Name: _		Middle Initial:	Last Name:	
Age:	Birth date:	School:	Grade:	Gender: □Male □Female
	C	HILD'S PERSONAL INFORM	ATION — Child #4	
First Name: _		Middle Initial:	Last Name:	
Age:	Birth date:	School:	Grade:	Gender: Male Female