Counseling and Treatment
Center of Utah

1220 N. Main St. #3 & 4
Springville, UT 84663

Identification

Name: _____ Date: _____

Chief concern

Please describe your child's main difficulty that has brought you to see me (e.g., symptoms, behaviors etc.):

Treatment

1. Has your child ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

❑ No ❑ Yes If yes, please indicate:

When? From whom? For what? With what results?

2. Has your child ever taken medications for psychiatric or emotional problems? ❑ No ❑ Yes If yes, please indicate:

When? From whom? Which medications? For what? With what results?

Relationships:

Please describe the following:

1. Your child's relationship with peers: _____

2. Your child's relationship with other family members: _____

3. Your child's development (e.g., delays with walking or talking, head injuries, complicated pregnancy etc.):

Academic History:

Please explain your child's school history(e.g., grades, suspensions etc.)

Abuse history

My child has been abused physically, sexually, emotionally, or verbally ❑ No ❑ Yes

If yes, please explain:

Medical History

Does your child have any medical illnesses? ❑ No ❑ Yes. If yes, please explain:

Other

Is there anything else that is important for me to know about your child, and that you have not written about on any of these forms? If yes, please tell me about it here: