B.Y.R.C.S
4250 Cessna St
Bldg 270
Boise, ID 83705
Office:(208) 272-8393
(208) 272-8392
Beyond the Yellow Ribbon Counseling Services

Minor Client Background Information

Please answer all information as completely as possible. Information will be managed as protected health information and beneficial in providing the best possible service.

Date: _____

Name of Child/Adolescent:

_____

First Middle Last

Age: _____ **Date of Birth**: _____ **Sex**: M___ F ___ Other_____

Address:_____

PARENT INFORMATION:

Mother's Info:

_____

First Middle Last Age

Father's Info:

_____

First Middle Last Age

Step-parent (mother) Info:

_____

First Middle Last Age

Step-parent (father) Info:

_____

First Middle Last Age

Legal Guardian's name (If different than above):

_____

First Middle Last Age

Home Phone: _____ May call ☐ Yes ☐ No Message ☐ Yes ☐ No

Work Phone: _____ May call ☐ Yes ☐ No Message ☐ Yes ☐ No

Cell Phone:_____ May call ☐ Yes ☐ No Message ☐ Yes ☐ No

Best time/means to contact parent: _____

Race/Ethnicity:_____ **Occupation**:_____ **Household Income**: _____

In case of emergency, contact:

_____

Name Relationship Phone

Present Family:

Please identify the family you currently live with and current nature of your relationship with each member.
List the members of your current family from oldest to youngest. Use back if more space is needed

Name	Relationship	Age	Currently this relationship is ... *i.e. good, neutral, conflictual etc.*

Who has primarily taken care of your child/adolescent most of his/her life?

_____

_____

_____

Who has legal custody of your child?

_____

Describe the environment your child/adolescent is currently living in (example: loving, chaotic, tense):

_____

_____

_____

Who is the primary disciplinarian in your family? _____

How would you describe the discipline in your home? Check all that apply:
❑ Strict ❑ Lenient ❑ Harsh ❑ Consistent ❑ Inconsistent ❑ Effective ❑ Shaming ❑ Positive

Does child/adolescent comply with disciplinary action?
❑ Always ❑ Usually ❑ Sometimes ❑ Rarely ❑ Never

Do parents/guardians agree in parenting, rules, and discipline?
❑ Always ❑ Usually ❑ Sometimes ❑ Rarely ❑ Never

Has your child/adolescent experienced any stress related to the following circumstances? Check and describe all that apply:

☐ financial problems _____
☐ frequent moves ___ _____
☐ drinking/drug problems _____
☐ frequent arguments in the home _____
☐ separation/divorce of parents __ _____
☐ frequent physical punishment _____
☐ mental illness in family _____
☐ death in family _____
☐ other _____

Please list 3 of your **family's** major strengths:

1. _____
2. _____
3. _____

Please list 3 of your **family's** greatest weaknesses:

1. _____
2. _____
3. _____

Health History:

Has your child's/adolescent's physical development been normal? ☐ Yes ☐ No If no, please explain:

_____
_____
_____

Has your child/adolescent had any chronic health problems? ❑ Yes ❑ No If yes, please explain:

_____
_____

Has minor ever been sexually and or physically abused? ❑ Yes ❑ No
If yes, was abuse reported to state authorities? ❑ Yes ❑ No*
**If No, please refer to HIPAA information about mandated reporting*

Date of LAST complete physical exam: _____

Any significant results: _____

Is child up-to-date on recommended immunizations? ❑ Yes ❑ No

Is child currently taking any medication or homeopathic? ❑ Yes(Please list below) ❑ No

Name of Current Medication	Dosage	Frequency	Purpose	Prescribing Doctor

Please list child's past and current medical conditions (major illness/injuries/surgeries/etc.)

What	When	Treatment

Is child in physical pain? ☐ Yes☐ No If yes, where? _____

_____

How long has child experienced this type of Pain? _____

Mental Health History:

Treatment Experience	YES	NO	Inpatient/ Outpatient	Dates	Was treatment Helpful?		
Individual Counseling					YES	SOME	NO
Family Counseling					YES	SOME	NO
Developmental Therapy/PSR					YES	SOME	NO
Psychiatric Services					YES	SOME	NO
Drug/Alcohol/Sexual Addiction Treatment					YES	SOME	NO
Self-Help Group					YES	SOME	NO
Hospitalization					YES	SOME	NO

Has child ever attempted ending their life? ☐ Yes ☐ No
Has child ever harmed self intentionally? ☐ Yes ☐ No
Has anyone in your immediate family attempted or committed suicide? ☐ Yes ☐ No
If yes to any, when? _____

Did someone refer you to BYRCS? ❑ Y ❑ N If so, who? _____

Alcohol/Substance Use:
Does/has your child used any of the following substances:

❑ Alcohol ❑ Tobacco ❑ Narcotics ❑ Prescription Other: _____

Date of last use:_____

Type and amount of usage? _____

_____

Age usage began? _____

Has minor ever had any legal problems related to your use/consumption? ❑ Yes ❑ No

Spirituality:
Does family practice a faith or religion? ☐Yes ☐No If so, please identify: _____
Would you like faith to be a part of treatment? ☐Yes☐No
If Yes, please describe what this might look like?
_____

Education History:
What school is your child currently attending?
_____

Grade level _____

What kind of grades does your child receive?
_____

Please list any scholastic or behavioral challenges your child/adolescent may have faced in:

Preschool: _____
Kindergarten: _____
Grades 1-3: _____
Grades 4-5: _____
Middle School:_____
High School: _____

Has your child ever been diagnosed with a learning disability? ☐ Yes ☐ No If yes, please explain:
_____
_____

Is your child/adolescent dealing with any school-related issues currently? ☐ Yes ☐ No If yes, please explain:

_____

_____

_____

Is your child currently on a 504 Plan or IEP? ☐ Yes ☐ No If yes, please describe:

_____

_____

Social History

How does your child/adolescent get along with his /her siblings?

☐ Better than Average ☐ Average ☐ Worse than average ☐ Doesn't have any siblings

How easily does your child/adolescent make friends?

☐ Better than Average ☐ Average ☐ Worse than average ☐ Doesn't have any friends

About how many close friends does your child have?

☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

Describe your child socially:

☐ With-drawn ☐ Insecure ☐ Passive ☐ Out-going ☐ Aggressive Other _____

What extracurricular activities is your child/adolescent involved in?

_____

_____

What jobs/chores does your child/adolescent have?

_____

_____

Additional Information

What are your child's/adolescent's strengths?

_____

_____

_____

What does your child struggle with?

_____

_____

_____

Is there anything else about your child/adolescent or family that we should know in order to be more helpful?

_____
_____
_____

Current Concerns:
Please describe below your main reason for seeking counseling for this child/adolescent (please be specific):

_____
_____
_____
_____
_____
_____
_____

When did this issue begin?

_____
_____
_____

Approximately how much distress do you believe these problems are causing in your life?

- ☐ Mild (less than once a week)
- ☐ Moderate (1-2 times per week)
- ☐ Severe (4-5 times per week)
- ☐ Impairing (Daily)

Have there been any significant life changes or stressful events that have impacted this issue?

_____
_____
_____

What is your family currently doing to deal with this issue?

_____
_____
_____
_____
_____

What would you like your child/adolescent to accomplish through counseling?

_____
_____
_____
_____

Pediatric Symptom Checklist

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

	NEVER	SOMETIMES	OFTEN
1. Complains of aches and pains.....	1		
2. Spends more time alone.....	2		
3. Tires easily, has little energy.....	3		
4. Fidgety, unable to sit still.....	4		
5. Has trouble with teacher	5		
6. Less interested in school	6		
7. Acts as if driven by a motor.....	7		
8. Daydreams too much.....	8		
9. Distracted easily.....	9		
10. Is afraid of new situations.....	10		
11. Feels sad, unhappy.....	11		
12. Is irritable, angry.....	12		
13. Feels hopeless.....	13		
14. Has trouble concentrating.....	14		
15. Less interested in friends.....	15		
16. Fights with other children.....	16		
17. Absent from school often.....	17		
18. School grades dropping.	18		
19. Is down on him or herself.....	19		
20. Visits to the doctor with doctor finding nothing wrong...	20		
21. Has trouble sleeping.....	21		
22. Worries a lot.....	22		
23. Wants to be with you more than before.....	23		
24. Feels he or she is bad.....	24		
25. Takes unnecessary risks.....	25		
26. Gets hurt frequently.....	26		
27. Seems to be having less fun.....	27		
28. Acts younger than children his or her age.....	28		
29. Does not listen to rules.....	29		
30. Does not show feelings.....	30		
31. Does not understand other people's feelings.....	31		
32. Teases others.....	32		
33. Blames others for his or her troubles.....	33		
34. Takes things that do not belong to him or her.....	34		
35. Refuses to share.....	35		