Leah E. Neese, M.A., LPC

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Client/Child's Name:	Date of Birth:	Today's Date:
Address:		

Emergency Contact Name:	Relationship:

Home Phone Number	Work Phone Number	Cell Number
Where may I contact you? Home	Work Cell (Circle all that apply)	Email

School Name	School Address

Who Referred You to Ms. Neese?	
Does your child have a primary care physician and/or psychiatrist? Yes No	If so, may I contact them if needed? Yes No
If you grant me permission to contact your PCP or psychiatrist, please provide their name & telephone number:	
Please list any medication(s) your child is presently taking (prescription & over the counter):	

Mother's Name:	Address	Phone Number
Father's Name:	Address	Phone Number

Billing Information		
Responsible Party:		
How will you be paying for services today and in the future? (circle all that apply) **Cash/Check PayPal Insurance**		
Address:		
Phone Number: Home Work Cell		
SSN:	**Date of Birth**	
Relationship to Client		
*****In the event that there is a missed appointment, no-show, or cancellation without twenty-four hours notice, I authorize Leah E. Neese, M.A., LPC to use the following credit card information for payment.*** (**REQUIRED INFORMATION**)		
Discover Visa MasterCard American Express (Circle one)		
Name as it Appears on Card:	**Card Number:**	**Expiration Date:**
Three-digit number printed on the back of your card (AMEX has a 4-digit number printed on the front of the card):		
Email:	**Home Phone Number:**	
Signature:	**Date:**	

Insurance Information - Primary Carrier Only		
Insurance Company:	**Policy ID:**	**Group Number:**
Name of Insured:	**Insured's Date of Birth:**	**Insured's Employer:**
Insured's Phone Number:		**Insurance Company's Phone Number (back of card):**

Release of Information

Your privacy is important to me and I want to protect your personal health information. If there is someone who you would like for me to release information to, please ask for the Release of Information paperwork.

The following confidential information will be used to provide me with a more complete understanding of your child. If you have any doubts about your answer, respond to the best of your ability. Thank you for your assistance.

Referral Situation
What recent events or emotional/behavioral problems have led to you seeking assistance for your child?
Please state in your own words the nature of your child's present problems/symptoms:
Were your child's problems/symptoms first noted by someone else? If so, by whom?
Please describe briefly your goals and expectations for your child and what you hope may be accomplished by this evaluation or through counseling:
In a few words, what do you think counseling is all about?
How long do you think your counseling should last?

Child's Personal and Social History	
Date of Birth:	**Place of Birth:**
Siblings:	
Number of Brothers:	**Brothers' Ages:**
Number of Sisters:	**Sisters' Ages:**
Father: **Living?** **If alive, give father's present age:** **If deceased, give his age at time of death:** **Cause of death:** **Father's occupation:**	**Mother:** **Living?** **If alive, give mother's present age:** **If deceased, give her age at time of death:** **Cause of death:** **Mother's occupation:**
Religion:	
Education: What is the last grade completed (degree)?	

Circle any of the following that apply:		
Happy childhood	School problems	Medical problems
Unhappy childhood	Family problems	Alcohol abuse
Legal trouble	Drug abuse	Strong religious convictions
Emotional/Behavioral problems	Others:	

Has your child ever been hospitalized for psychological problems? If yes, when & where:	
Has your child ever attempted suicide? If so, when?	Has any relative attempted or committed suicide?
Does any member of your family suffer from alcoholism, epilepsy, depression or anything else that might be considered a "mental disorder"?	

Analysis of Current Stress

The following section is designed to help you describe your child's current stress in greater detail and to identify problems which might otherwise go unnoticed. This will enable me to design a comprehensive treatment program and tailor it to your child's specific needs.

Circle any of the following behaviors that apply to your child:		
Overeat	Suicidal attempts	Can't keep a job
Take drugs	Compulsions	Insomnia
Vomiting	Smoke	Take too many risks
Odd behavior	Withdrawal	Lazy
Drink too much	Nervous tics	Eating problems
Work too hard	Concentration difficulties	Aggressive behavior
Procrastination	Sleep disturbance	Crying
Impulsive reactions	Phobic avoidance	Outbursts of temper
Loss of control	Others:	

Are there any specific behaviors, actions or habits that you would like your child to change?
What are some special talents or skills your child feels proud of?
What would your child like to do more of?
What would you like your child to do less of?
What would you like your child to start doing?
What would you like your child to stop doing?
How is your child's free time spent?

Feelings:	***Circle any of the following feelings that often apply to your child:***	
Angry	Guilty	Unhappy
Energetic	Annoyed	Happy
Bored	Relaxed	Sad
Conflicted	Restless	Tense
Depressed	Regretful	Lonely
Anxious	Hopeless	Contented
Fearful	Hopeful	Excited
Panicky	Helpless	Optimistic
Others:		

What feelings would your child most like to experience more often?
What feelings would your child like to experience less often?
What are some positive feelings your child has experienced recently?
When is your child most likely to lose control of your feelings?

Describe any situations that make your child feel calm or relaxed:
Does your child have trouble relaxing and enjoying weekends and vacations? (If yes, please explain):

Physical Sensations:	***Circle any of the following that often apply to your child:***	
Headaches	Stomach trouble	Skin problems
Dizziness	Tics	Visual disturbances
Dry mouth	Fatigue	Hearing problems
Palpitation	Twitches	Burning or itchy skin
Muscle spasms	Flushes	Chest pains
Tension	Numbness	Back pain
Rapid heart beat	Watery eyes	Tremors
Don't like being touched	Sexual disturbances	Tingling
Excessive sweating	Unable to relax	Fainting spells
Blackouts	Bowel disturbances	Hear things
Other:		

Image:	***Circle any of the following that apply to your child:***	
Pleasant sexual images	Unpleasant sexual images	Aggressive images
Unpleasant childhood images	Lonely images	Images of being loved
Helpless images	Seduction images	
Other:		

I Picture Myself:	***Circle any of the following that apply to your child:***	
being hurt	hurting others	being followed
not coping	being in charge	being laughed at
succeeding	failing	being trapped
losing control	Other:	

Thoughts: ***Circle each of the following thoughts that apply to your child:***
I am worthless, a nobody, useless and/or unlovable.
I am unattractive, incompetent, stupid and/or undesirable.
I am evil, crazy, degenerate and/or deviant.
Life is empty, wasted; there is nothing to look forward to.
I make too many mistakes, I can't do anything right.

Circle each of the following words that your child might use to describe himself/herself:		
intelligent	confident	trustworthy
loyal	worthwhile	unattractive
confused	ambitious	considerate
worthless	useless	memory problems
full of regrets	a nobody	sensitive
attractive	morally degenerate	a deviant
crazy	unlovable	honest
inadequate	stupid	conflicted
ugly	naive	good sense of humor
incompetent	horrible thoughts	can't make decisions
concentration difficulties	suicidal ideas	persevering
hard-working	Other:	

What do you consider to be your child's most irrational thought or idea:

Friendships

Does your child make friends easily?

Does he/she you keep them?

Was your child ever bullied or severely teased?

Circle the degree to which your child generally feels comfortable and relaxed in social situations:

Very relaxed Relatively comfortable Relatively uncomfortable Very anxious

Does your child have one or more friends with whom he/she feels comfortable sharing his/her most private thoughts and feelings?

Biological Factors

Does your child have any current concerns about your physical health? Please specify:

Does your child eat three well-balanced meals each day? If not, please explain:

Does your child get regular physical exercise? If so, what type and how often?

Check any of the following that apply to your child:

	Never	Rarely	Frequently	Very Often
Marijuana				
Tranquilizers				
Sedatives				
Aspirin				
Cocaine				
Painkillers				
Alcohol				
Coffee				
Cigarettes				
Narcotics				
Stimulants				
Hallucinogens (LSD, etc)				

Check any of the following that apply to your child:

	Never	Rarely	Frequently	Very Often
Diarrhea				
Constipation				
Allergies				
High blood pressure				
Heart problems				
Nausea				
Vomiting				
Insomnia				
Headache				
Backache				
Early morning awakening				
Fitful sleep				
Overeat				
Poor appetite				

Circle any of the following that apply to your child or members of your family:

thyroid disease	kidney disease	Asthma	Neurological diseases
diabetes	Cancer	Gastrointestinal disease	Prostate problems
Glaucoma	Epilepsy		

Has your child ever had any head injuries or loss of consciousness? Please give details:

Please describe any surgery your child has had (give dates):

If you wish to add any additional comments/information to this form, please feel free to do so in the space below.