BROWARD
CENTER FOR COUNSELING

BROWARD CENTER FOR COUNSELING
8030 PETERS ROAD, SUITE D-106
PLANTATION, FL 33324

CLIENT HISTORY INFORMATION
FOR CHILDREN / ADOLESCENTS

The information requested in this questionnaire is necessary for the planning of the services to be rendered to your child. Please fill it out as completely as possible. If you do not understand a question or do not know the answer, please leave that question blank. However, please try and answer fully as many questions as you possibly can.

It is understandable that you might be concerned about what happens to the information about you because much or all of this information is highly personal. Case records are strictly confidential. **NO OUTSIDER IS PERMITTED TO SEE YOUR CASE RECORD WITHOUT YOUR PERMISSION.**

If you do not desire to answer any questions, merely write "Do not care to answer".
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Date: ____/_____/_____ REFERRED by:_____

Child's Name: _____

Age_____ D.O.B._____/_____/_____ Sex M ☐ F ☐

Parent's names: Mother: _____ Father: _____

Telephone
HOME:_____ WORK: _____ CELLULAR:_____

Address:_____City:_____State_____ Zip_____

Email:_____

Insured's Company name:_____

Insurance Member ID #:_____ Ins. Tel #:_____

Patient's relationship with insured:_____

Responsible party employed by :_____

Occupation:_____ Work Tel # _____

Child resides with: Mother ____ Father ____ Both Natural parent(s) _____ Foster parent(s)_____
Adoptive parent(s) _____ **(check one)**
Other (specify) _____

Other people living in the home?

NAME	AGE	RELATIONSHIP	HIGHEST GRADE COMPLETED
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

SCHOOLS ATTENDED	GRADE(S)	ACADEMIC GRADES	CONCERNS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

	CURRENTLY	PAST	AGE
SPEECH PROBLEMS	_____	_____	_____
BEHAVIOR PROBLEMS	_____	_____	_____
HYPERACTIVITY	_____	_____	_____
AGGRESSION	_____	_____	_____
SEXUAL ACTIVITY	_____	_____	_____
POOR SCHOOL BEHAVIOR	_____	_____	_____
PROBLEMS W/TEACHER	_____	_____	_____
PROBLEMS W/AUTHORITY	_____	_____	_____
PROBLEMS W/PEERS	_____	_____	_____
DIFFICULTY SLEEPING	_____	_____	_____
DIFFICULT TO DISCIPLINE	_____	_____	_____
GETS UPSET EASILY	_____	_____	_____
TEMPER TANTRUMS	_____	_____	_____
NAIL BITING	_____	_____	_____
THUMB SUCKING	_____	_____	_____
LEGAL PROBLEMS	_____	_____	_____
PROBLEMS W/ALCOHOL	_____	_____	_____

	CURRENTLY	PAST	AGE
NIGHTMARES	_____	_____	_____
BEDWETTING	_____	_____	_____
MASTURBATING EXCESSIVELY	_____	_____	_____
PROBLEMS W/DRUGS	_____	_____	_____
DEPRESSION	_____	_____	_____
ANXIETY	_____	_____	_____
SUICIDAL THOUGHTS OR ATTEMPTS	_____	_____	_____
PROBLEMS W/EATING	_____	_____	_____
DEATH IN FAMILY	_____	_____	_____
PARENTS SEPARATED / DIVORCED	_____	_____	_____
PARENTS REMARRIED	_____	_____	_____
RECENT MOVE OR PLANS TO MOVE	_____	_____	_____

PRESENTING PROBLEMS:

What are you most concerned about with your child?_____

_____

_____

_____

What is your spouse most concerned about? _____

_____

_____

What does the school believe to be the problem? _____

_____

In what situations is the problem most apparent? _____

_____

Least apparent?_____

Who generally disciplines the child? _____

What methods are used? _____

Do parents agree on methods of discipline?_____

Elaborate if "no":_____

MEDICAL INFORMATION:

Who is your child's present physician: _____
name

_____
Address Phone number

Is your child currently on any medications? Yes or No If yes, what medications and dosages are they on? _____ _____

_____

LIST BELOW ANY DISEASE, CONDITIONS OR OTHER MEDICAL PROBLEMS INCLUDING VISION OR HEARING YOUR CHILD/ADOLESCENT HAS EXPERIENCED AND HIS/HER AGE AT THAT TIME:

_____
_____

HAVE YOU CONSULTED OTHER THERAPISTS OR PSYCHIATRIST REGARDING YOUR CHILD/ADOLESCENT?

IF YES, NAME / TELEPHONE NUMBER: THERAPIST OR PSYCHIATRIST

_____
_____

CONSENT FOR TREATMENT: PLEASE BE ADVISED THAT BOTH PARENTS MUST CONSENT TO THERAPY FOR A MINOR:

_____ _____
MOTHERS SIGNATURE FATHERS SIGNATURE

CONTACTING DOCTORS: WE BELIEVE WE CAN OFFER THE UTMOST QUALITY OF CARE BY WORKING AS A TEAM WITH YOUR OTHER HEALTHCARE PROVIDERS. I AM WILLING TO ALLOW "BROWARD CENTER FOR COUNSELING" TO DISCUSS INFORMATION REGARDING SERVICES PROVIDED AT THIS OFFICE:

PRIMARY CARE PHYSICIAN NAME: _____ YES _____ NO _____
TELEPHONE NUMBER:_____ FAX:_____

PSYCHIATRIST NAME:_____ YES _____ NO _____
TELEPHONE NUMBER:_____ FAX:_____

This form was completed by (print your name)_____

SIGNATURE:_____

PREFERRED PHONE NUMBER TO REACH YOU: (_____) _____

May we leave a message for you on your voicemail? _____ yes _____ no

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT ON MY ACCOUNT AND THAT **"BROWARD CENTER FOR COUNSELING"** WILL VERIFY MY INSURANCE BENEFITS AS A COURTESY. I UNDERSTAND THAT I WILL BE HELD RESPONSIBLE FOR ANY OFFICE CHARGES NOT PAID BY MY INSURANCE COMPANY.

PATIENT/LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

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8030 Peters Road, Suite D-106
Plantation, FL 33324

Tel:954-475-9503 Fax: 954-476-2369
www.browardcenterforcounseling.com