Strong Roots Counseling
Parent introduction for child under 18-- completed by parent/guardian

Name of child: _____ D.O. B.:_____

Nickname:_____

Gender_____Preferred pronoun (ex: She/her/hers)_____

Name parent/guardian(s) (for minor child):_____

Gender_____Preferred pronoun (ex: She/her/hers)_____

Address: _____

City/town: _____ Zip: _____

Adolescent phone: _____ Parent/guardian phone: _____

Race:_____ Ethnicity:_____

Religion/ spiritual practice:_____

Email address for parent:_____

Emergency contact for child (must be over 18):_____

Emergency contact phone:_____

I understand that Strong Roots Counseling,Inc will contact my emergency contact only in case of an emergency. Strong Roots Counseling,Inc may be required to share limited clinical information with my emergency contact.

Name, address, and telephone number child's pediatrician:_____

_____

Permission to speak with child's pediatrician? (Please sign)_____

What are your goals for your child's time in therapy?

_____

What have you and/or they tried to solve the concerns bringing the child into therapy?

What do you imagine will be the first sign that our work with your child is successful?

How will we know your child is done with therapy?

Please list any other services/agencies/professionals involved with your child's care (please specify role and list names and phone numbers):

Please list prior therapists, psychiatrists, or mental health treatments, please list names and approximate dates of service.

Please list any physical, mental health issues, or substance use/abuse (past or present) for family members.

Please list all medication and/or herbal supplements your child is currently using or has used in the past.

Immediate family members (list all immediate family members; please list even if they do not live with you):

name	age	relationship to you	address

Do you have access to firearms in your home?_____

Do you feel safe in your home?_____

Sleep habits:

Does your child have trouble with sleep? ___Yes ____No
Does your child experience daytime sleepiness? ___Yes ___No
How many hours dos your child sleep most nights? _____
How long does it usually take to get to sleep once your child lay down? _____
If your child wake in the middle of the night, how long does it take to get back to sleep? _____
Is your child's current sleep pattern the same or different from their normal? _____

Here is a list of common areas for discussion. Please consider if you would like to discuss any of them during our time together. (Circle all that apply.)

Work or School
Close Relationships
Anxiety
Depression
Family
Sex
IVF
Sexual Identity/Orientation
Spiritual or Religious
Physical Health
Racism/Race
Money
Divorce
Substance Use/Abuse
Trauma
Eating Disorder
Grief and loss

Please use this space to share anything else important you think we should know about you, your

family, and/or your child._____

_____

_____

_____

How did you hear about us?

Friend Flyer Postcard Insurance Company Psychology Today

Therapist Colleague Birth professional Pediatrician Facebook Ad

Other:_____

Signature_____ Date_____