WELLSPRING COUNSELING

Parent Report for Dependent Child

Name _____ Date _____

Residential Parent(s)/Guardian(s)_____

Non-Custodial or Non-residential parent (if applicable)_____

_____

Address_____

Phone number _____

Why is your child coming in for counseling?

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

None = This symptom not present at this time
Mild = Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life and /or day-to-day functioning
Severe = Profound impact on quality of life

	None	Mild	Mod	Sev		None	Mild	Mod	Sev		None	Mild	Mod	Sev
depressed mood	☐	☐	☐	☐	binging/purging	☐	☐	☐	☐	guilt	☐	☐	☐	☐
appetite disturbance	☐	☐	☐	☐	laxative/diuretic abuse	☐	☐	☐	☐	elevated mood	☐	☐	☐	☐
sleep disturbance	☐	☐	☐	☐	anorexia	☐	☐	☐	☐	hyperactivity	☐	☐	☐	☐
elimination disturbance	☐	☐	☐	☐	paranoid ideation	☐	☐	☐	☐	dissociative states	☐	☐	☐	☐
fatigue/low energy	☐	☐	☐	☐	circumstantial symptoms	☐	☐	☐	☐	somatic complaints	☐	☐	☐	☐
psychomotor retardation	☐	☐	☐	☐	loose associations	☐	☐	☐	☐	self-mutilation	☐	☐	☐	☐
poor concentration	☐	☐	☐	☐	delusions	☐	☐	☐	☐	significant weight gain/loss	☐	☐	☐	☐
poor grooming	☐	☐	☐	☐	hallucinations	☐	☐	☐	☐	related medical condition	☐	☐	☐	☐
mood swings	☐	☐	☐	☐	aggressive behaviors	☐	☐	☐	☐	emotional trauma victim	☐	☐	☐	☐
agitation	☐	☐	☐	☐	conduct problems	☐	☐	☐	☐	physical trauma victim	☐	☐	☐	☐
emotionality	☐	☐	☐	☐	oppositional behavior	☐	☐	☐	☐	sexual trauma victim	☐	☐	☐	☐
irritability	☐	☐	☐	☐	sexual dysfunction	☐	☐	☐	☐	emotional trauma perpetrator	☐	☐	☐	☐
generalized anxiety	☐	☐	☐	☐	grief	☐	☐	☐	☐	physical trauma perpetrator	☐	☐	☐	☐
panic attacks	☐	☐	☐	☐	hopelessness	☐	☐	☐	☐	sexual trauma perpetrator	☐	☐	☐	☐
phobias	☐	☐	☐	☐	social isolation	☐	☐	☐	☐	substance abuse	☐	☐	☐	☐
obsessions/compulsions	☐	☐	☐	☐	worthlessness	☐	☐	☐	☐	other (specify)	☐	☐	☐	☐

Has your child ever been hospitalized for mental health treatment? ____ yes ____ no

Describe _____

_____

Has your child ever had prior mental health counseling or treatment? ____ Yes ____no

Describe _____

_____

Has your child ever participated in any form of self harm before? ____ Yes ____ no What

_____

Does your child have any suicidal thoughts at this time? ____ Yes ____no

Has your child ever tried to commit suicide? ____ Yes ____no How _____

WELLSPRING COUNSELING

Developmental History

Delayed Development or Long Term effects from events: check normal or check description and describe effect

Prenatal/Perinatal Events: ☐ Normal ☐ Description _____

Physical: ☐ Normal ☐ Description _____

Psychological: ☐ Normal ☐ Description _____

Social: ☐ Normal ☐ Description _____

Intellectual: ☐ Normal ☐ Description _____

Academic/Educational: ☐ Normal ☐ Description _____

Sexual Abuse History ☐ Normal ☐ Description _____

Physical Abuse History ☐ Normal ☐ Description _____

Trauma Related History ☐ Normal ☐ Description _____

Unconscious Life

Does your child have:

Nightmares and/or recurring dreams? _____

Unconscious habits? _____

Fears with unknown origins? _____

Obsessive/Compulsive acts or thoughts? (Behaviors you repeat over again and again or keep thinking about the same thing all the time) _____

_____

Social Life

What type of people is your child comfortable with (quiet, loud/talkative, leaders, etc) _____

_____

Would you consider your child more of a leader or a follower? _____

_____

What is your child's attitude toward social functions? _____

_____

List the things your child most enjoy doing with your free time _____

_____