KJ Hurt, Licensed Professional Counselor

Parent/Family Information Form

Client's Name:	Age:	Date of Birth:
Your Relation to Client:		Does the client live with you:

Please complete the following information about yourself (parent/family member) .

Your Name:		Today's Date:
Address:		Date of Birth:
City, State, Zip		Age:
Primary Phone:	Work/Alternate Phone:	E-mail Address:

Client's Treatment History (Describe any current/past counseling, mental health/substance abuse treatment *about the Client*)

Date	Provider	Problem/Issue	Duration	Outcome

Client's Medication Information (Indicate any medications that *the client* is now taking.)

Prescription Name	Being taken for?	How Long?	Results?

Referral Information

How did you hear about KJ Hurt?

***Your* (Parent/Family Member) Employment Information**

Employer:	
City Where Located:	
Position:	Hours per Week:

Your Reason(s) for coming to Counseling? Any other information you would like the counselor to know?

Information About Abuse to *the Client* (Indicate any known abuse to *the client*.)		
Emotional - Includes chronic discord between parents, yelling, screaming, cursing. Explain:	YES	NO
Physical - Includes hitting (w/hands or other object); pushing; withholding food, water, sleep. Explain:	YES	NO
Sexual - Includes words, looks, and touching: Explain:	YES	NO

Behavioral Observations of Client (Place an **X** next to each area that applies to *the Client*.)

Physical		***Peer Relations***		***Social/Academic***	
Intoxication		Change in Friends		Not informing parents of activities	
Change in Sleep Patterns		Associating w/known users		Change in grades	
Change in Dress		Secretive about peer activities		Dropping extra-curricular activities	
Change in Diet		Gang-related Activity		Suspension/Expulsion	
Frequent Illness		***Family Relations***		Referral to student assistant program	
Poor Coordination		Vagueness about whereabouts		Cheating	
Change in Hygiene		Frequent excuses		Truancy	
Low Endurance		Rebelliousness		Detentions	
Change in Weight		Disappearance of personal items/money		***Other***	
Mental/Emotional		Isolation at home		Drug paraphernalia found	
Unusual Mood Swings		Defiance of rules		Inappropriate sexual behavior	
Decreased Attention Span		Unexplained expenditures		Habitual use of eye drops, diet pills, etc	
Easily Frustrated		Liquor/Prescriptions missing		Secretiveness	
Suicidal Ideation/Attempt		Reacts strongly to talk about drug use		Promiscuity	
Defensiveness				Legal Involvement	
Time Disorientation		Other Observations or Information, please describe:			
Spiritual					
Decrease in church-related activity					
New religious beliefs					
Satanic symbols and/or discussion					
Cult involvement					

May we contact you at: ____ Home ____ Work ____ Mail ____ E-mail ____ Other:_____

Your Signature/Date:_____