

ACACIA RISING COUNSELING
Roxanne George, Ph.D., LMFT (License No. T0762)
Honoring Strength and Diversity in Individuals, Couples, and Families
1345 NW Wall Street, Suite 303, Bend, OR 97701; 389-5050 (Phone); 678-5482 (Fax)
Email: acaciarising@proaxis.com; Website: www.acaciarising.com

CHILD'S INFORMATION:

Name: First _____ Middle _____ Last _____
Gender: Male Female Date of Birth: ____/____/____ Age: ____
Race/Ethnicity (Mark all that apply): White/Caucasian Hispanic or Latino Black/African American Asian
 American Indian/ Alaskan Native Native Hawaiian/Pacific Islander Other _____
Does child have any disabilities? Yes No If yes, type of disability: _____
Child's School: _____ Grade: _____ Teacher's Name: _____
Insurance: Private OHP None Insurance Provider (if private): _____

LEGAL CUSTODIAN(S) INFORMATION:

Name: First _____ Middle _____ Last _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Relationship to Child: _____
Address(s): _____ City: _____ State: _____ Zip: _____
Mailing address if different: _____ City: _____ State: _____ Zip: _____

CAREGIVER INFORMATION:

Biological Mother **Adopted Mother** **Foster Mother** **Other** _____

Name: First _____ Middle _____ Last _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Address (if different from Legal Custodian's): _____ City: _____ State: _____ Zip: _____
Mailing address if different: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____
Employer: _____ Hours/Days at Work: _____

Education: (highest grade/degree completed): _____
Current Marital Status: Married Partnered Divorced Single Separated Widowed

Marriages or Significant Relationships (List present to past):

Name (to whom) _____ from _____ to _____ (dates)
Name (to whom) _____ from _____ to _____ (dates)
Name (to whom) _____ from _____ to _____ (dates)

Biological Father **Adopted Father** **Foster Father** **Other** _____

Name: First _____ Middle _____ Last _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Address (if different from Legal Custodian's): _____ City: _____ State: _____ Zip: _____
Mailing address if different: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____
Employer: _____ Hours/Days at Work: _____

Education: (highest grade/degree completed): _____
Current Marital Status: Married Partnered Divorced Single Separated Widowed

Marriages or Significant Relationships (List present to past):

Name (to whom) _____ from _____ to _____ (dates)
Name (to whom) _____ from _____ to _____ (dates)
Name (to whom) _____ from _____ to _____ (dates)

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FAMILY/CHILD CARE INFORMATION:

Name of Child's Stepfather/Step-parent: _____ Date of Birth: ____/____/____ Age: _____

Name of Child's Stepmother/Step-parent: _____ Date of Birth: ____/____/____ Age: _____

Name of Child's Full and/or Half Siblings:	Date of Birth:	Age:	Biological Parent(s):
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____

Name of Child's Stepbrothers / Stepsisters:	Date of Birth:	Age:	Biological Parent(s):
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____

If parents are not together, what is the status of the custody agreement? Resolved Unresolved In Progress

If parents are not together, what is the visitation schedule: _____

How many times has child moved in his/her life? _____ List all households child has lived at in last 3 years (*present to past*):

Place (City & State)	Who else lived there	Approx. age of child at that time
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has child or caregiver ever been homeless, lived in a shelter, or been placed in foster care: Yes No Unknown

If yes, when _____, Please explain: _____

Please list other people who have taken care of the child (babysitters, relatives, daycare providers, etc)

Name	Relationship to child	Approx. age of child at that time
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any prior concerns of neglect, or physical/sexual/emotional abuse to this child or siblings? Yes No Unknown

If yes, please describe briefly: _____

Have either parent or anyone else in the family experienced any type of abuse or neglect? Yes No Unknown

If yes, please describe briefly: _____

Have there been any significant stresses in the child's family (such as death, major illness, conflict between family members, divorce, job loss, moves, etc) in the last year? Please explain: _____

BEHAVIORAL & SOCIAL INFORMATION:

If the child is in school, how are they doing?

Academically Good Fair Poor Unknown Explain: _____
 Socially Good Fair Poor Unknown Explain: _____
 School Attendance Good Fair Poor Unknown # of days missed in last month: _____
 Ever Suspended or Expelled? Unknown No Yes If yes, explain: _____

Does child have any learning problems? Unknown No Yes If yes, explain: _____

Individual Education Plan (IEP) or special education placement? Unknown No Yes Explain: _____

Please identify any behaviors that have been of concern for the child recently (within the past 3 to 6 months)?

<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Often	Nightmares and/or sleep problems
<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Often	Fear of people, places, or situations
<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Often	Anger or aggression (tantrums, hitting others)
<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Often	Sexualized behavior or play
<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Often	Withdrawal from friends/family
<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Often	Sadness (lasting more than a few hours)
<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Often	Nervous habits (nail biting, picking at skin, etc.)
<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Often	Lying or stealing
<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Often	Hyperactivity or difficulty concentrating
<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Often	Injuries to self (cutting, burning, scarring)
<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Often	Cruelty or harm to animals
<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Often	Eating problems or changes in appetite
<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Often	Match or fire play (burned toys, papers, grass, household items)

Other behavior concerns: _____

Have the following ever occurred for the child or the child's family (please check each item; mark "None" if not applicable):

- Mental health concerns (depression, anxiety, bipolar, PTSD, ADHD, anger, etc.):
 For child (explain): _____ Current Past Unknown None
 For family (explain): _____ Current Past Unknown None
- Family history of (circle) self harm/cruelty to animals/eating disorders/other: Current Past Unknown None
 Please explain: _____
- Exposure to violence between adults in the home environment?
 For child (explain): _____ Current Past Unknown None
 For family (explain): _____ Current Past Unknown None
- Alcohol use:
 For child (explain): _____ Current Past Unknown None
 For family (explain): _____ Current Past Unknown None
- Drug use:
 For child (explain): _____ Current Past Unknown None
 For family (explain): _____ Current Past Unknown None
- Child exposed to sexual activity or walked in on adults having sex: Current Past Unknown None
- Child exposed to pornography on TV, movies, videos, magazines, computer: Current Past Unknown None
- Previous child protective services involvement (DHS, CPS) Current Past Unknown None
- Previous law enforcement involvement (criminal charges, home visits, court): Current Past Unknown None
- Financial strain or unemployment (explain): _____ Current Past Unknown None
- Guns or weapons in the household NOT locked up? Current Past Unknown None

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What types of discipline are used on the child?

_____ Occasionally Often
_____ Occasionally Often
_____ Occasionally Often

Has child ever been in counseling? Unknown No Yes If yes, reason: _____

Name of therapist: _____ Phone _____ Dates _____

Have other family members ever been in counseling? Unknown No Yes If yes, reason: _____

Name of therapist: _____ Phone _____ Dates _____

Child's interests, activities, and accomplishments:

What household chores are assigned to your child? _____

What are your child's main hobbies and interests: _____

What does your child enjoy doing most? _____

What does your child dislike doing most? _____

List three things you like most about your child? _____

List three things you are most concerned about? _____

MEDICAL INFORMATION:

Child's Regular Health Care Provider (Dr., PA-C, FNP, etc): _____

Clinic name & address (provide as much as possible): _____

Approximate date of last visit? _____ Reason for last visit: _____

List any medical concerns or problems (chronic illness, asthma, seizures, bleeding problems, allergies, etc.) for this child:

Does child take any medications? Yes No Unknown If yes, please explain: _____

Are child's immunizations up to date? Yes No Unknown If no, please explain: _____

Do you have any questions or concerns about today's appointment?

I certify that the above information is true and correct to the best of my knowledge.

Legal Custodian of child _____ / _____ / _____
Date

Foster Parent Signature _____ / _____ / _____
Date

I authorize Roxanne George to collaborate, as needed, with my child's health care providers.

Legal Custodian of child _____ / _____ / _____
Date

Foster Parent Signature _____ / _____ / _____
Date