CWCSF

Counseling and Wellness Center of South Florida

___Staci Lee Schnell, M.S.,C.S., LMFT
___Joele Amster, M.S.
___Lexa Goldman, MA, LMHC, LMFT
___Holly McIntyre, MSW, LCSW
___Caela Cohen, M.S.Ed.
___Katrina Lorenzo, M.S.
___Jody Schultz, M.Ed, M.S.
___Nyla Whitehead, M.S.
___Dr. Alena Prikhidko, LMFT
___Jordan Nodelman, MSW, LCSW
___Alexandra Haves, MS, EdS
___Dr. Nathalie Bello, LMFT
___Jennifer Artesani Blanks, M.Ed., LMHC
___Katalin Hanana, MS, LMHC
___Ellen Rondino, M.S., LMFT
___Marni Winters, M.S., LMHC
___Dr. Liana Lorenzo- Echeverri, LMFT
___Anna Schafer Edwards, M.S., MBA
___Cassandra Cacace, M.S.
___Sally Duerr Rodriguez, M.S., LMHC
___Michelle Bennett, M.S.

Child/Adolescent Information

Welcome to the practice. To speed up the initial process if you would please fill out this form as completely as possible, we will be able to get started quickly. All information provided will be kept confidential within the guidelines expresses in the Client Handbook. Thank you.

Please Print

Child Name:_____ Date:_____ FILE #_____
Address:_____
(City)_____ State:_____ Zip:_____
Age:___ Date of Birth:___/___/___ Gender_____

Place of Birth:_____How long have you lived in Florida?_____
School/Grade:_____
Employed/Hours a week:_____
Extra Curricular Activities/Hour a week:_____
_____
Describe the primary reason for coming to counseling:_____
_____
_____
_____
_____

Parents' Signatures_____

Whom may I thank for referring your family?
Name:_____Address:_____
City:_____State:_____Zip:_____Phone:_____
We give our permission to send a letter of acknowledgment to our referral source:
_____
(Parent Signature)

Parent #1's Name:_____
Address if different:_____
(City)_____ State:_____ Zip:_____
Age:___ Date of Birth:___/___/___ Gender_____

	OK to Contact		OK to send/leave message	
Email Address:_____	Y	N	Y	N
Home Telephone:_____	Y	N	Y	N
Work Telephone:_____	Y	N	Y	N
Cell Phone:_____	Y	N	Y	N

Place of Birth:_____How long have you lived in Florida?_____
Military Service: Branch:_____ From_____To_____
Education:_____
Current Occupation:_____
Employed By:_____
Address;_____
(City):_____State:_____Zip:_____

Parent #2's Name:_____
Address if different:_____
(City)_____ State:_____ Zip:_____
Age:___ Date of Birth:___/___/___ Gender_____

	OK to Contact		OK to send/leave message	
Email Address:_____	Y	N	Y	N
Home Telephone:_____	Y	N	Y	N
Work Telephone:_____	Y	N	Y	N
Cell Phone:_____	Y	N	Y	N

Place of Birth:_____How long have you lived in Florida?_____
Military Service: Branch:_____ From_____To_____
Education:_____
Current Occupation:_____
Employed By:_____
Address;_____
(City):_____State:_____Zip:_____

Parents' Signatures_____

Family Information

Current Parents' Marital Status:

Married: _ Divorced: _ Separated;_ Widowed: _ Co-Habitating:_
Single: _ Engaged: _ Other_____

List all Child's household members:

Name	Age	Relationship	Occupation/(School/Grade)
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____
5._____	_____	_____	_____
6._____	_____	_____	_____

Parent #1: Please list all of <u>your</u> marriages or significant relationships.

Name of Spouse	Date Married	Children from this Relationship	Terminated (Death/Date, Divorced/Date)
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____

Parent #2: Please list all of <u>your</u> marriages or significant relationships.

Name of Spouse	Date Married	Children from this Relationship	Terminated (Death/Date, Divorced/Date)
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____

Child Medical and Psychotherapy History

Parents please fill out:

Any Surgeries? Yes □ No □

Procedure	Date	Comments/Outcome
_____	_____	_____
_____	_____	_____

Any current medical diagnosis or diseases? Yes □ No □

Diagnosis	Date	Comments/Status
_____	_____	_____
_____	_____	_____

Any current treatments or therapies for these conditions? Yes □ No □

_____

Family Impact of Diagnosis:

Any previous psychotherapy? Yes □ No □

Date Started	Date Completed	Purpose of Therapy	Therapist
_____	_____	_____	_____

How helpful was it? Much improved □ Somewhat improved □ Improved □
Worse □ Somewhat worse □ Much worse □ No change □

Any hospitalizations? Yes □ No □

Date	Hospital	Reason
_____	_____	_____
_____	_____	_____

Current Medications:

Medication	Dose	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____

May I contact physician(s) to co-ordinate treatment? Yes □ No □

Parents' Signatures_____

Child Clinical Information

Parents please fill out:
Child Name: _____ Parents' Signatures: _____

Please check all items that **your child** has experienced in the last 6 months:

Physical Symptoms
- □ Headaches
- □ Fainting Spells/ Dizziness
- □ No appetite/Overeating
- □ Stomach/ Bowel disturbances
- □ Palpitations
- □ Tremors – shaking
- □ Poor sleep
- □ Nightmares/ Night Tremors
- □ Unusual bodily sensations
- □ Sexual Problems
- □ Tired/No Energy

Emotional Symptoms
- □ Anxious
- □ Depressed
- □ Self-Esteem Issues
- □ Fears/Worries
- □ Inferiority feelings
- □ Panic Attacks
- □ Anger Issues
- □ Feeling Tense/Stressed
- □ Shy
- □ Poor Decision Making
- □ Lack Ambition or Interests
- □ Unable to relax

- □ Other_____

Social/Family Issues
- □ Marital/Partner problems
- □ Parent/Child problems
- □ Unemployed/Work Issues
- □ Financial Problems
- □ Court/Legal problems
- □ Problems making/keeping friends

Addictions
- □ Drinking problem
- □ Drug Abuse
- □ Gambling
- □ Sexual Addiction
- □ Food Addiction
- □ Excessive Shopping

Mental Health
- □ Previous Suicide Attempts
- □ Suicidal Ideas
- □ Visual Hallucinations
- □ Hearing Voices
- □ Disturbing thoughts or fears
- □ Manic

Please describe in detail those items checked above and for how long you have been experiencing each:

_____
_____
_____
_____
_____
_____

Clinical Information

To be filled out by Child/Adolescent if able:

Name: _____ Signature: _____

Please check all items that **you** have experienced in the last 6 months:

Physical Symptoms

- □ Headaches
- □ Fainting Spells/ Dizziness
- □ No appetite/Overeating
- □ Stomach/ Bowel disturbances
- □ Palpitations
- □ Tremors – shaking
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- □ Shy
- □ Poor Decision Making
- □ Lack Ambition or Interests
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□ Other_____

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- □ Hearing Voices
- □ Disturbing thoughts or fears
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Please describe in detail those items checked above and for how long you have been experiencing each:

_____

_____

_____

_____

_____

_____