N-Courage Counseling, LLC
875 Market Street
Lemoyne, PA 17043
(717)897-0484

Child Information Form

Please type or print the following information.

Name: _____

Date of Birth: ___/___/_____ Age: _____ Gender: _____

Address: _____

(Street) (City) (State) (Zip code)

Phone numbers: _____

(cell) (other)

Email address: _____

How do you prefer to be contacted? _____

Emergency Contact Name: _____ Emergency Contact Number: _____

Parent's names: _____

School District: _____ Grade currently attending: _____

Favorite subject at school: _____Religious orientation: _____

Please list all people living with you, relationship to you, and ages:

Have any members of your family been diagnosed with a psychological disorder such as Depression, Anxiety, Bi-polar, ADHD, Schizophrenia, or Substance Use disorder? (please list) _____

_____

List any current health concerns and/ or medications you are taking: _____

_____

_____

Primary Care Physician: _____

(Name) (Address) (Phone)

NAME:

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Have you utilized psychological services in the past? Yes / No

If yes, list years and issues addressed: _____

If yes, what was beneficial and what wasn't: _____
_____

Have you ever been hospitalized for psychological purposes? If so, please list approximate dates and reason for admission: _____
_____

In the past 6 months have you had thoughts of killing yourself? _____

In the past 6 months have you had thoughts of killing someone else? _____

Have you considered or attempted suicide in the past? _____
_____

Do you engage in self-harming behaviors such as cutting, burning or punching yourself? _____

Frequency of alcohol use: _____ Frequency of other substance use: _____

Describe the main concerns in your life right now: _____
_____
_____
_____
_____
_____
_____

If you experience any of the following, please list frequency:

Sleep issues:_____

Headaches: _____

Panic symptoms: _____

Stomachache/GI distress: _____

Nightmares: _____

NAME:

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The following is a list of symptoms which are common in various psychological disorders, please highlight or circle all symptoms which you have experienced in the past month:

Depressed mood	Excessive anxiety or worry	Eating until uncomfortably full	Unusually high self-esteem
Loss of interest or pleasure	Difficulty managing worry	Eating alone due to embarrassment	Increased rate of speech
Weight loss or gain	Restlessness	Feeling out of control	Little need for sleep
Slowed thoughts and movements	Irritability	Feelings of guilt after overeating	Increase in risky activities
Fatigue	Specific fears	Purging or restricting	Pacing, hand wringing
Daily feelings of worthlessness or guilt	Difficulty falling or staying asleep	Unwanted, upsetting memories	More distracted than usual
Difficulty concentrating	Avoid social situations	Strong startle response	Relational conflict
Recurrent thoughts of death	Sweating, nausea, diarrhea	Nightmares or flashbacks	Decreased functioning at work

Please include any additional information which will be helpful to our work together: _____
_____
_____
_____
_____
_____
_____
_____

NAME: