LAKE COUNTRY ASSOCIATES, INC.
515 Bridge Street East, Park Rapids, MN 56470 ph: 218-366-9229
1426 Bemidji Ave NW, Ste 1 Bemidji, MN 56601 ph: 218-444-2233
11 Main Street East Menahga, MN 56164 ph: 218-564-9229
Fax: 218-237-2520

Date: _____

General Information *Please provide the following information and answer the questions. Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.*

Child's Name: _____ Child's Age: _____ Date of Birth (DOB): _____
Mailing Address: _____
Physical Address: _____
Race: ☐ White ☐ Black/African American ☐ Asian ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ Alaskan/Native American Tribe: _____

Bio Parent's Name: _____ Bio Parent's Name: _____

Emergency Contact: _____ Phone # _____

I authorize Lake Country Associates, Inc. to release necessary information to my emergency contact in the event of emergency **Initial: _____**

Cell phone: _____ May I leave a message? ☐ Yes ☐ No
Home phone: _____ May I leave a message? ☐ Yes ☐ No
Work phone: _____ May I leave a message? ☐ Yes ☐ No
Email: _____ May I email you? ☐ Yes ☐ No
(For appointment scheduling purposes only, as email is not considered a confidential medium of communication)

Was your child referred to Lake Country Associates? Please provide agency/professional's name and phone number:

Name: _____ Phone: _____

May I contact the agency/person to thank them for referring you? ☐ Yes ☐ No Please Initial: _____

Concerns

What is the main reason(s) you're seeking help for your child? (Include how long he/she's had these symptoms or problems):
_____
_____
_____

What are your hopes regarding your child's therapy? _____
_____
_____
_____

Health & Mental Health Information

Does your child currently have any medical problems? _____
_____
_____

Who is your child's primary care physician? _____
When was your child's last complete physical exam (mo/year)? _____
Has your child ever been treated for any of the following? If so, please circle and describe: Head injury or loss of consciousness, frequent ear infections, tubes placed, hearing or vision problems, headaches, meningitis, seizures, asthma, elevated lead levels, slow/fast growth, allergies, cancer, surgeries, any other conditions: _____
_____
_____
_____
_____
_____
_____

Who is your child's psychiatrist (if applicable)? _____
_____

Has your child previously seen a therapist or psychiatrist? If so, what year? _____ Who did he/she see and for what reason?
_____
_____
About how many meetings did your child have? Was the experience helpful or not? How so? _____
_____
Has your child ever been hospitalized for medical or mental illness? If so, list when, where, & reason: _____
_____
_____
_____
Please list your Child's current prescription medications with dosage (psychiatric and general health): _____
_____
_____
_____
Please list any previous psychiatric medications (with dosage and dates): _____
_____
Do you suspect or know if your child drinks alcohol or uses recreational drugs? _____
If so, what kind & how often? _____
_____
Do you or anyone close to your child consider his/her use to be a problem? ☐ Yes ☐ No
If so, who? _____ Why? _____
How many times a week does your child exercise? _____ What type & how many minutes? _____
_____

Your Child's Family

	Biological Mother	**Biological Father**
Current age **(If deceased – date, age, & cause of death)**		
Country of Origin (Race)		
Occupation		
Religious/Spiritual Affiliation **(Cultural Issues if any)**		
Highest grade completed		
Any history of the following: Please circle	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse
Describe each parent's relationship with the child Give some examples of the things that you do together & feelings you have		

Parents are (choose one): ☐ Married ☐ Separated ☐ Divorced ☐ Living together ☐ Never Coupled
If separated or divorced, how old was your child when the separation occurred? _____
Child lives with (choose one): ☐ Both Parents ☐ Mother ☐ Father ☐ Other: _____
Who has current legal guardianship of child? (Please provide legal papers if they exist) _____
_____
Please describe the current visitation schedule (if any) and the type of communication with child's other parents(s): _____
_____

Siblings

Please list your child's brother and sisters in the order of birth (including adopted or step siblings).

First Name	Biological, Adopted, or Step	Current Age	School Grade?	Male/ Female	Lives with you? (Yes/No)	Any medical, social or academic problems? (please list for each)

Family Mental Health History

In the section below identify if any members of your family and extended family have a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please Circle		List Family Member(s)
Anxiety (general)	Yes	No	
Obsessive Compulsive Behavior	Yes	No	
Depression	Yes	No	
Suicide Attempts	Yes	No	
Bipolar/Manic Depressive	Yes	No	
Alcoholism	Yes	No	
Substance Abuse	Yes	No	
Domestic Violence	Yes	No	
Eating Disorders	Yes	No	
Obesity	Yes	No	
Schizophrenia	Yes	No	
Counseling or Psychotherapy	Yes	No	
Psychiatric Hospitalizations	Yes	No	

Your Child's Developmental History

Pregnancy and Birth

Age of mother at birth: _____ Length of pregnancy? _____ Weeks

Were there any complications during pregnancy (high blood pressure, diabetes, hospitalization)? If so, please describe:

_____

Were there any complications during delivery? If so, please describe: _____

Length of stay in hospital? Mother: _____ (days) Child: _____ (days) Birth weight: _____

Medications used during pregnancy? Please list: _____

Smoking? ☐ Yes ☐ No How much? _____

Alcohol intake? ☐ Yes ☐ No How much? _____ Drug intake? ☐ Yes ☐ No How much? _____

Developmental Milestones and Early Development

At what age did your child do the following (indicate approximate month or year of age for each): Turn over _____

Crawl_____ Stand Alone _____ Walk Alone _____ Talk _____ First Words _____

First Phrases _____

Currently toilet trained? ☐ Yes ☐ No If yes, days? _____ Nights? _____

Has your child wet or soiled themselves after being trained? ☐ Yes ☐ No If yes, until what age? _____

Enjoyed cuddling? ☐ Yes ☐ No Fussy, Irritable? ☐ Yes ☐ No More active than other babies? ☐ Yes ☐ No

If your child has siblings, was development different in any way? Explain: _____

_____

Your Child's School, Home, Social & Personal Functioning

School/Academics

Your child's current grade? _____ Have they ever repeated a grade? ☐ Yes ☐ No If yes, which grade? _____

School Name: _____ ☐ Public ☐ Private

Street Address: _____

School District/County: _____ Phone: _____

What preschool experience did your child have? _____

Where any problems detected in your child's kindergarten screening? ☐ Yes ☐ No If so, please explain: _____

_____

Is your child in a regular classroom? ☐ Yes ☐ No Does your child have an IEP? ☐ Yes ☐ No

Has your child ever received tutoring? ☐ Yes ☐ No If so, please explain: _____

_____

What are your child's typical grades? _____

What are you child's strongest and weakest points academically? _____

_____

Are you satisfied with your child's educational program? ☐ Yes ☐ No Please explain: _____

_____

Home/Family Life

What are 5 things that you enjoy most about your child? _____

_____

What are some activities you engage in as a family? _____

_____

Does you child participate in religious or faith-based groups? _____

Does your child listen and obey instructions 75% of the time? ☐ Yes ☐ No _____

What are your discipline techniques? _____

_____

What are **your** strengths personally and as a parent? _____

_____

What are some of **your** areas of needed growth? _____

_____

What are your **child's** strengths (things he/she is good at)? _____

_____

What are your **child's** areas of needed growth? _____

_____

Social and Community Engagement

What are your child's favorite activities or hobbies? _____

In what extracurricular/community activates is her/she involved? _____

How does your child get along with other children? _____

Who are some of your child's closest friends? (first names) _____

_____

Has your child experienced any stressors (recent or during the past year) that may be contributing to his/her difficulties? (e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, child changed school, family moved, family financial problems, remarriage, sexual trauma, other losses)? ☐ Yes ☐ No If yes, please describe: _____

_____

_____

Please provide any additional information which you would like me to know or which you would feel would be helpful to better understand your child: _____

_____

_____

_____

Your Child's Symptoms or Problems

How much are each of the following areas currently a problem for your child? (Please circle)

	Not at all	A little	Somewhat	Considerably	Terribly
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Depression	1	2	3	4	5
Alcohol or Substance Abuse	1	2	3	4	5
Parent-Child Conflicts	1	2	3	4	5
Sibling Conflicts	1	2	3	4	5
Social Relationships	1	2	3	4	5
School Problems	1	2	3	4	5
Sexual Problems	1	2	3	4	5
Spiritual/Religious	1	2	3	4	5
Legal Problems	1	2	3	4	5
Eating Disorder	1	2	3	4	5
Abuse (Physical, Emotional, Sexual)	1	2	3	4	5

Please add any other information that would help us help your child:

_____
_____
_____
_____
_____
_____