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

Child's Name: ________________________________________ Date: _______________

## Welcome to Lake Country Associates

This form is meant to provide your counselor information to help in providing thorough and relevant therapy services, as well as to make the best use of the session time today.

### Reason for Referral

Main problems for which services are being sought: ______________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Goals you hope to achieve by coming for services: ______________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

### Cultural/Religious Background

Cultural/ethnic/religious beliefs/practices: ______________________________________________________
______________________________________________________________________________________

Does the cultural/ethnic/religious background affect the client's mental health or services? ☐ No ☐ Yes

### Mental Health History

Has this client received mental health services in the past? ☐ No ☐ Yes: ____________________________________

Is there any history of mental health problems in the family? ☐ No ☐ Yes – please specify below

### 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 client in the space provided.

| | Please Circle | | Relationship to Client |
|---|---|---|---|
| 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 | ______________________ |
| Schizophrenia | Yes | No | ______________________ |
| Counseling or Psychotherapy | Yes | No | ______________________ |
| Psychiatric Hospitalizations | Yes | No | ______________________ |

## Medical History

Has this client experienced any major illnesses and/or do they have any ongoing medical conditions?

☐ No ☐ Yes: ______________________________________________________________________

Any significant family health/medical history? ☐ No ☐ Yes: ____________________________________________

Current medications, including over-the counter (OTC) items taken: ☐ No Current Medications

| Medication | Dosage | Provider/OTC |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

High caffeine use for client: ☐ No ☐ Yes: ________________________________________________________
Drug/alcohol/tobacco use concerns for client: ☐ No ☐ Yes: _____________________________________________
History of drug/alcohol abuse in the family: ☐ No ☐ Yes: ______________________________________________

## Educational History

<u>Clients Ages 0-5</u>

Does this child attend: ☐ Head Start ☐ Preschool ☐ Childcare ☐ ECSE ☐ Other: ___________________________

<u>Clients- Aged 5-18</u>

| | | | |
|---|---|---|---|
| Attendance: | ☐ Rarely Absent | ☐ Sometimes Absent | ☐ Frequently Absent |
| Academic Abilities: | ☐ Above Average | ☐ Average | ☐ Below Average |
| Peer Relations: | ☐ Above Average | ☐ Average | ☐ Below Average |
| Behavior: | ☐ Above Average | ☐ Average | ☐ Below Average |

<u>All Clients</u>

Has this child been tested for special education: ☐ No ☐ Yes Disability if known: ___________________________
Does this child have a current IEP/IFSP: ☐ No ☐ Yes

## Current Living Environment

| | | | |
|---|---|---|---|
| ☐ Comfortable | ☐ Supportive | ☐ Chaotic | ☐ Abusive |
| ☐ Positive family relationships | ☐ Family relational problems | | |
| ☐ Home in good repair | ☐ Home needs repair | | |
| ☐ Safe neighborhood | ☐ Safety concerns in the neighborhood | | |
| ☐ Financially stable | ☐ Financially stressed | | |

Comments:_____________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**Pregnancy/Development**

Complications during the pregnancy: ☐ No ☐ Yes: ____________________

Substance use during the pregnancy: ☐ No ☐ Yes

Tobacco use during the pregnancy: ☐ No ☐ Yes

Length of Pregnancy: ☐ Full Term ☐ Premature Birth: ____________________

Complications during delivery: ☐ No ☐ Yes

Birth Weight: ________ Length: ________

| Mastery of Developmental Milestones | **Early** | **Average** | **Delayed** |
|---|---|---|---|
| Sitting without support | ☐ | ☐ | ☐ |
| Rolling over | ☐ | ☐ | ☐ |
| Crawling | ☐ | ☐ | ☐ |
| Walking alone | ☐ | ☐ | ☐ |
| First words | ☐ | ☐ | ☐ |
| 2-3 word sentences | ☐ | ☐ | ☐ |
| Toilet trained – Daytime | ☐ | ☐ | ☐ |
| Toilet trained – Nighttime | ☐ | ☐ | ☐ |

Has the client experienced any of the following?

Sleep problems: ☐ No ☐ Yes Comments: ____________________

Feeding/eating problems: ☐ No ☐ Yes Comments: ____________________

Hearing/vision problems: ☐ No ☐ Yes Comments: ____________________

Social problems: ☐ No ☐ Yes Comments: ____________________

Out of home placement: ☐ No ☐ Yes Comments: ____________________

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 |

Provide further information on above areas: ____________________

____________________

____________________

**Form Completed by:** ____________________ **Relationship to Client:** ______________