# COSBY & COSBY COUNSELING AND CONSULTATION, LLC

Client's Last Name________________________________ First Name____________________________________ M.I.____

Birth Date_______________ Age_____ Grade______ School__________________________________________________

Date of Examination__________________ Form filled out by: ____Mother ____Father ____Client ____ Other _________

Ofc Use: Start Time ___________ End Time _____________ Client ID#____________________

**GENERAL INFORMATION**

A1. Presenting Problem/s

Child/Teen's view of problem (**DO NOT COMPLETE)**

A2. GENERAL FAMILY INFORMATION
Parents or Guardian

Name: ___________________________________________________________________________________

Mother's Highest Education Level: ______________ Father's Highest Education Level: ________________

Guardian's Highest Education Level: ________________ Information provided by: ____________________

Relationship to Patient: ____________________

Child's Living Arrangements

The child lives with: ___both parents ___ Mother ___ Father ___ Step parent _____ Grandparents

_______ Foster Parents Other___________________________________________________________

How many other children live with the child? ______ How long in present living arrangement? ___________

How often have the custodial arrangements changed? _______________________________________________

A3. Family Life Domain Deficits and/or Stressors

___ the loss of their home
___ parental divorce
___ death of a family member
___ serious illness of a family member
___ trauma
___ child abuse or neglect
___ parental separation
___ unsafe home environment
___ incarceration of a family member
___ loss of employment of a major wage earner
___ family violence
___ other _______________________________________

A4. Family history of drugs/alcohol abuse? _____ Yes ____No (Describe)

| List Problem | Mother's Side<br>Relationship to Patient (no names) | Father's Side |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |
| | | |

A5. Family History of Psychiatric Illnesses: _____ Yes _____ No (Describe)

| Problem | Mother's Side<br>Relationship to Patient (no names) | Father's Side |
| --- | --- | --- |
| _____ Anxiety Disorders | | |
| _____ Attention Deficit Disorder | | |
| _____ ADD with Hyperactivity | | |
| _____ Child Physical Abuse | | |
| _____ Child Sexual Abuse | | |
| _____ Spouse/Partner Abuse | | |
| _____ Depression | | |
| _____ Learning Disabilities | | |
| _____ Major Legal Problems | | |
| _____ Manic-Depressive Illness | | |
| _____ Neurological Disorders | | |
| _____ Physical Disabilities | | |
| _____ Psychotic Behavior | | |
| _____ Suicide | | |
| _____ Other _____________________ | | |

**PERSONAL HISTORY (CHILD/TEEN)** Developmental History

B1. Pregnancy and Birth Information

According to ______________________________________________________________________________

_____born with no apparent complications _____ born past due date _____ weeks
_____experienced anoxia at birth _____ was born premature _____ weeks ____________weight
_____experienced in utero exposure to drugs/alcohol
_____spent time in neonatal ICU _____days _____weeks
_____other_______________________________________________________________________________

B2. Developmental Milestones Achieved (check only one for each milestone)

According to ______________________________________________________________________________

| | Early | Typical | Late | Unknown |
|---|---|---|---|---|
| Sitting alone | _____ | _____ | _____ | _____ |
| Crawling | _____ | _____ | _____ | _____ |
| Standing alone | _____ | _____ | _____ | _____ |
| Walking alone | _____ | _____ | _____ | _____ |
| Speaking first words | _____ | _____ | _____ | _____ |
| Speaking short sentences | _____ | _____ | _____ | _____ |
| Using toilet when awake | _____ | _____ | _____ | _____ |
| Staying dry at night | _____ | _____ | _____ | _____ |
| Other ______________________ | _____ | _____ | _____ | _____ |

B3. Sensory/Motor Status (check all that apply)

____ has no sensory or motor problems
____ has visual difficulty
____ is supposed to wear corrective lenses in class
____ has mild hearing difficulty
____ has a substantial hearing difficulty
____ has an allergy-related hearing difficulty
____ is supposed to wear a hearing aid
____ has pressure equalization (PE) tubes
____ has fine motor movement difficulties
____ has gross motor movement difficulties
____ Other _______________________________________________________________________________

B4. Neurological Status (check whether the use is at test time or in the past)

| | In the Past | Currently |
|---|---|---|
| No sign of neurological concerns | ____ | ____ |
| Episodes of head banging | ____ | ____ |
| Seizures or convulsions | ____ | ____ |
| A serious head injury | ____ | ____ |
| A motor tic | ____ | ____ |
| Periods of unconsciousness | ____ | ____ |
| An unusual number of accidents | ____ | ____ |

Other ______________________________________________________________________________

**Medical/ Mental Health**

C1. Medical/Mental health history. List current (C) and past(P) conditions and treating physician(s). (Check all that apply)

| | Physician | Medication(s) |
|---|---|---|
| _____ No major medical/psychiatric conditions | | |
| _____ Asthma | ______________________ | ______________________ |
| _____ Chronic Ear Infections | ______________________ | ______________________ |
| _____ Fetal Alcohol Syndrome | ______________________ | ______________________ |
| _____ Lead Poisoning | ______________________ | ______________________ |
| _____ Multiple Sclerosis | ______________________ | ______________________ |
| _____ Muscular Dystrophy | ______________________ | ______________________ |
| _____ Seizure Disorder | ______________________ | ______________________ |
| _____ Diabetes | ______________________ | ______________________ |
| _____ Spina Bifida | ______________________ | ______________________ |
| _____ other ____________________ | ______________________ | ______________________ |
| _____ other _____________________ | ______________________ | ______________________ |
| _____ Anxiety Disorder | ______________________ | ______________________ |

Continued

| | | |
|---|---|---|
| ______ Depressive Disorder | ______________________ | ______________________ |
| ______ Mood Disorder | ______________________ | ______________________ |
| ______ Thought Disorder | ______________________ | ______________________ |
| ______ Attention Deficit Disorder | ______________________ | ______________________ |
| ______ Attention Deficit/Hyperactivity Disorder | ______________________ | ______________________ |
| ______ Speech Difficulties | ______________________ | ______________________ |
| ______ other ______________________ | ______________________ | ______________________ |

C2. Relevant family medical history (describe):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

C3. Allergic to any medications?

______Yes ______ No (If yes please specify) ________________________________________________

______________________________________________________________________________

______________________________________________________________________________

C4. Allergies?

______ Yes ______ No (If yes specify) _____________________________________________

C5. Six-month history of prescribed (list physician) and frequently used over-the-counter medications:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

C6. Current use of Alcohol/other drugs by patient? _______ Yes _______ No (Describe)

______ Marijuana Describe ____________________________________________________

______ Opiates Describe ____________________________________________________

______ other(s) Describe ____________________________________________________

C7. Past use of Alcohol/other drugs by patient? _______ Yes _______ No (Describe)

______ Alcohol Describe ____________________________________________________

______ Marijuana Describe ____________________________________________________

______ Opiates Describe ____________________________________________________

______ other(s) Describe ____________________________________________________

C8. Past psychiatric and/or alcohol/drug treatment: ______ Yes ______ No (Describe)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**LEGAL**

D1. Relevant legal history? _____ Yes _____ No (Describe) List current and/or past legal problems

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

D2. Currently on probation? ____ Yes ____ No (Describe)

D3. Court-ordered treatment? ____ Yes ____ No

______________________________________________________________________________

______________________________________________________________________________

**CHILD EDUCATION/SCHOOL**

E1. Highest grade completed_____ dropped out at _____ grade _____ repeated grade(s)

E2. Currently enrolled in: ___ Preschool GED K 1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th

_____ Attended Preschool _____Attended Kindergarten

E3. Name and phone number of counselor or contact person: ___________________________________________

E4. Special Education Placement? ____ Yes ____ No Date of last IEP or 504 meeting ___________________

Type of placement: ____Speech ____LD ____OHI ____ Autism ____Dev Delay ____ Other

Comments: ______________________________________________________________________

E5. Strengths in school: _________________________________

E6. Problems in school: Past (P) Current (C)

____ Attendance
____ Difficulty w/ peers
____ Difficulty w/teachers
____ Failing grades
____ Repeated grades
____ Behavior/Conduct Problems
____ Other ________________________________________________________________________
____ Frequent office referrals
____ In School Suspensions
____ Out of School Suspensions
____ Expulsion
____ Criminal activity in school

E7. Specific school release signed? ____Yes ____No ____N/A