Linda Piantieri, MA, NCC
Licensed Mental Health Counselor
Licensed Marriage & Family Therapist
1850 Lee Road, Suite 212, Winter Park, FL 32789 Phone: 407-719-2525
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Child's Name_____

Name Child Prefers to be called_____

Address_____

Mother's Name_____

Occupation _____Work phone_____

Address_____

Home Phone _____Cell Phone_____

Email Address_____

Father's Name_____

Occupation _____Work phone_____

Home Phone _____Cell Phone_____

Email Address_____

Please list everyone who <u>lives with the child</u> who is not listed above.

Name_____Age_____

Relationship to Child_____

Cell phone number _____Email address_____

Name_____Age_____

Relationship to Child_____

Cell phone number _____Email address_____

Child's name_____

Name_____Age_____

Relationship to Child_____

Cell phone number _____Email address_____

Name_____Age_____

Relationship to Child_____

Cell phone number _____Email address_____

Name_____Age_____

Relationship to Child_____

Cell phone number _____Email address_____

Religion/spiritual beliefs of child/parents_____

Amount parents drink: _____daily _____weekly _____monthly

Have you felt the need to cut down on your drinking? _____yes _____no

Do you feel annoyed by people complaining about your drinking? _____yes _____no

Do you ever feel guilty about your drinking? _____yes _____no

Do you ever drink an eye-opener in the morning to relieve the shakes _____yes _____no

Medications/drugs used by parents_____

_____

_____

_____

Child's Name_____

Health

Does the child have normal eyesight? _____Date last exam_____

Does the child have normal hearing? _____ Date last exam_____

Name, phone number, and address of pediatrician or other doctor_____

_____

_____

Any Surgeries? _____

Briefly summarize important factors in the child's health history

_____

_____

_____

_____

_____

_____

Handicaps/

Disabilities_____

_____

_____

Child’s Current Medications, dosage, when taken, and length of time on each

Child's Name_____

Child's current physician's and psychiatrist's name, address, and phone numbers:

Other Counseling or Therapy

Has your child previously seen or is your child currently seeing another counselor or therapist? If so, please list the name of the counselor/therapist, the name of the agency consulted (if applicable), the topics of concern for which assistance was requested, and the time period for which counseling was conducted.

Briefly describe circumstances that prompted you to request counseling at this time.

Child's Name_____

Please use the space below to tell me anything that you think is relevant

Signature of person filling out this form:_____

Please print name signed above:_____

Date:_____