



LEGACY COMPREHENSIVE COUNSELING & CONSULTING

19751 E. MAINSTREET SUITE 215 - PARKER CO 80138

WWW.LEGACYPARKER.COM - PHONE: 303-841-4005

OR INFO@LEGACYPARKER.COM

Child's Demographic Information:

Last Name: _____ First Name: _____ MI: _____ Birthdate: _____ Gender: _____

Nickname: _____ Ethnicity (Optional): _____

Address: _____ City: _____ Zip: _____

Home Phone: _____

Mother's Cell: _____ Father's Cell: _____ Child's Cell: _____

List all phone #'s you authorize Legacy to leave messages on: _____

Who should be contacted to schedule appointments? _____

I authorize Legacy to send Newsletters and/or program updates via e-mail and/or mail: ____ Yes ____ No

Parent/Guardian Information:

Mother's Name: _____ Mother's Address: _____

Mother's Email: _____ Mother's Employer: _____

Father's Name: _____ Father's Address: _____

Father's Email: _____ Father's Employer: _____

Who is financially responsible for this child? _____

Referral Information

Who referred you to Legacy Comprehensive Counseling & Consulting? _____

Referring Provider's Profession (**circle**): Physician/Pediatrician Teacher Counselor Other: _____

Reason for the referral? _____

Form Filled out by: _____ Signature _____ Date: _____

Primary Insurance Information:

Who is responsible for payments made to Legacy (Parent Name)? _____

Insurance Company Name: _____ ID #: _____ Group # _____

Policy Holder Name: _____ Policy Holder DOB: _____ Policy Holder SS #: _____

LCCC Office Use Only:

Present at Intake Session: _____

Developmental History:

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Did the biological mother receive prenatal care during the (check the box that applies): First Trimester: <input type="checkbox"/> Yes <input type="checkbox"/> No Second Trimester: <input type="checkbox"/> Yes <input type="checkbox"/> No Third Trimester: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Drugs used by mom during pregnancy (specify trimester):	
Medical Interventions during pregnancy:	

Birth History:

LCCC Office Use Only

Child's gestation: _____ Weeks	
Weight: _____ lbs _____ oz.	
Drugs used during child's labor/delivery: ____ Yes ____ No	
Complications: ____ Yes ____ No	
Child's physical condition at birth: APGAR score:	
Was the child admitted to the NICU? ____ Yes ____ No If yes, please describe interventions: If yes, how long was your child in the NICU?	

Developmental Milestones:**LCCC Office Use Only**

Developmental Skill:	Age Acquired	Concerns	
Sat alone			
Crawled			
Stood Alone			
Walked Alone			
Said single word			
Said 2-3 word sentences			
Toilet training Day: Night:			
Fine Motor Skills (coloring, writing, etc.)			

LCCC Office Use Only

Social Skills:			
Eye contact			
Responded to Smile			
Parallel Play			
Interactive Play			
Identified someone as a best friend			

LCCC Office Use Only

Primary language Spoken in the home			
Secondary language Spoken in the home			

Child's Prescribing Physician's Name:**LCCC Office Use Only**

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Medical History:**LCCC Office Use Only**

Describe any significant past/current illnesses:	
Describe any significant past/current surgeries:	

Medical History, continued:	
Describe any significant past/current allergies:	
Describe any past hospitalizations:	
Describe any past psychiatric hospitalizations:	
Describe any significant past/current head injuries/concussions: Did your child lose consciousness? ____ Yes ____ No If so, for how long? _____ Did your child black out? ____ Yes ____ No Did you seek medical attention for your child? ____ Yes ____ No What other symptoms did your child experience?	
Describe any accidents/trauma:	
Describe any environmental trauma your child may have experienced (e.g., tornados, floods, hurricanes, etc.):	
Describe any sexual/physical/mental abuse:	

LCCC Office Use Only

Medication Name:	Dosage:	Date Began:	Date Ended:	

LCCC Office Use Only

Describe any concerns regarding your child's vision:	
Is your child color blind? If yes, please explain:	
Describe any concerns regarding your child's hearing:	
Physician's Name: Physician's Phone: Physician's Address:	

LCCC Office Use Only

How is your child's sleep patterns?	
How is your child's appetite?	

Therapy / Treatment History:**LCCC Office Use Only**

Treatment Provider	Type of Service (speech therapy, occupational therapy physical therapy, vision therapy, etc.)	Approximate Dates of Services	
<p>Has your child ever been diagnosed with a mental health diagnosis? If yes, what?</p> <p>What provider gave the diagnosis?</p>			
<p>Has anyone (besides the current referring provider) ever recommended that your child receive an evaluation or assessment? If yes, who?</p> <p>Why was a recommendation made for an evaluation?</p>			
<p>Has your child ever received counseling in the past? If yes, from whom?</p> <p>When did your child receive counseling? ____Yes ____No</p> <p>How do you feel your child responded to the counseling services provided?</p>			
<p>Has your child had previous testing? (tutoring center, school, child find or early intervention)? If yes, please described the type of testing your child received:</p> <p>Did your child receive a diagnosis? ____Yes ____No</p> <p>What recommendations were made as a result of the evaluation?</p>			
<p>Is your child currently receiving any alternate therapies (acupuncture, homeopathic, herbal, biofeedback, etc.)? If yes, please explain:</p>			
<p>Has your child received genetic testing? ____Yes ____No</p> <p>If no, has this even been recommended?</p> <p>If yes, what were the results?</p>			

Sensory History:**LCCC Office Use Only**

Does your child appear clumsy or uncoordinated? ____Yes ____No	
Would you describe your child as a picky eater? If yes, what foods will your child eat?	
Does your child avoid messy play (paint, sand, play-doh)? ____Yes ____No	
Does your child have difficulties with boundaries (frequently touching, kicking or biting others)? ____Yes ____No	

Behavior History:**LCCC Office Use Only**

Concerning Behavior	Age Began	Duration	Severity	Cause of Behavior Problem (people, events, etc)	

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Please describe your child's typical mood:	
Please describe your child's personal strengths:	
Please list any of your child's extracurricular activities:	

LCCC Office Use Only

Does your child display any repetitive behaviors? ____Yes ____No	
Does your child repeatedly say any words over and over? ____Yes ____No	
Has your child ever had an ability or skill and then lost it? ____Yes ____No	
Does your child have any restricted interests? ____Yes ____No	
Does your child use any alcohol and/or illicit drugs? If yes, please describe:	
Has your child had any legal or criminal issues or involvement with law enforcement authorities? If yes, please describe issues and the date of involvement:	

Discipline History:**LCCC Office Use Only**

Method:	Frequency:	Consistency among caregivers?	Effectiveness	

LCCC Office Use Only

Other Discipline Notes:	
What percentage of the time does your child currently obey the first time he/she is asked?	

Family History:

List all Family Members Living in your child's home:

LCCC Office Use Only

Name:	Gender:	Age:	Relationship to you:	

LCCC Office Use Only

List any learning/educational problems in your family (immediate and extended):	
List any mental health problems in your family (immediate or extended):	
List any drug or alcohol problems in your family (immediate or extended):	
List any behavioral problems in your family (immediate or extended):	

Family History, continued:**LCCC Office Use Only**

Maternal Education:	
Paternal Education:	
Are your child's parents divorced?	
If yes, please answer the following questions: Please describe custody arrangements for your child: Who has mental health care decision making for your child? Who has medical care decision making for your child? Who has religious decision making for your child?	

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Describe any past family Dept. of Human Services involvement:	
Describe any current family Dept. of Human Services involvement:	
Does your family currently have a caseworker? ____ Yes ____ No	

School History:**LCCC Office Use Only**

Name	Time Frame at Daycare/School (In years)	Teacher	Child's Behavior	Learning, Attention, Special Services	

LCCC Office Use Only

Current Grade in School:	
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Day Care/School History, continued :	
Does your child have a current or past IEP (Ind. Education Program)? If yes, date of last IEP:	
Does your child have a current or past ILP (Ind. Learning Program)? If yes, date of last ILP:	
Does your child have a current or past RTI (Response to Intervention)? If yes, date of last RTI:	
Does your child have a 504? If yes, date of last 504:	
What special service's through the school has/does your child receive? ____ LD ____ ED Other _____	
Has your child ever repeated a grade? ____ Yes ____ No	
Has your child ever skipped a grade? ____ Yes ____ No	
Does your child like school? ____ Yes ____ No	
How does your child react to redirection for behavior at school	
Please describe any suspensions/detentions:	

Social History:

LCCC Office Use Only

Are there any concerns about your child's ability to form friendships? ____ Yes ____ No	
Are there any concerns about your child's social skills? ____ Yes ____ No	
Are there any concerns about your child's coping skills? ____ Yes ____ No	

Current Concerns (Main reasons for coming to Legacy):	LCCC Office Use Only																						
<p>Current Concern #1:</p> <p>When did the problem begin:</p> <p>What have you tried that has not worked:</p> <p>What have you tried that has worked:</p>																							
<p>Current Concern #2:</p> <p>When did the problem begin:</p> <p>What have you tried that has not worked:</p> <p>What have you tried that has worked:</p>																							
<p>Current Concern #3:</p> <p>When did the problem begin:</p> <p>What have you tried that has not worked:</p> <p>What have you tried that has worked:</p>																							
<p>What are your primary goals for seeking treatment for your child?</p> <p>1.</p> <p>2.</p> <p>3.</p>																							
<p>Is your child experiencing any of the following?</p> <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Sad or depressed</td> <td><input type="checkbox"/> Energy loss</td> </tr> <tr> <td><input type="checkbox"/> Loss of interest</td> <td><input type="checkbox"/> Concentration Difficulties</td> </tr> <tr> <td><input type="checkbox"/> Weight change</td> <td><input type="checkbox"/> Impulsiveness</td> </tr> <tr> <td><input type="checkbox"/> Change in eating habits or appetite</td> <td><input type="checkbox"/> Hyperactive</td> </tr> <tr> <td><input type="checkbox"/> Too little sleep</td> <td><input type="checkbox"/> Irritability</td> </tr> <tr> <td><input type="checkbox"/> Too much sleep</td> <td><input type="checkbox"/> Angry or mad</td> </tr> <tr> <td><input type="checkbox"/> Worthlessness/Guilt</td> <td><input type="checkbox"/> Restlessness</td> </tr> <tr> <td><input type="checkbox"/> Suicidal plans</td> <td><input type="checkbox"/> Behavior problems</td> </tr> <tr> <td><input type="checkbox"/> Suicidal thoughts</td> <td><input type="checkbox"/> Nightmares</td> </tr> <tr> <td><input type="checkbox"/> Aggressive Behavior</td> <td><input type="checkbox"/> Harm towards self and/or others</td> </tr> <tr> <td><input type="checkbox"/> Anxiety</td> <td></td> </tr> </table> <p>Anything else:</p>	<input type="checkbox"/> Sad or depressed	<input type="checkbox"/> Energy loss	<input type="checkbox"/> Loss of interest	<input type="checkbox"/> Concentration Difficulties	<input type="checkbox"/> Weight change	<input type="checkbox"/> Impulsiveness	<input type="checkbox"/> Change in eating habits or appetite	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Too little sleep	<input type="checkbox"/> Irritability	<input type="checkbox"/> Too much sleep	<input type="checkbox"/> Angry or mad	<input type="checkbox"/> Worthlessness/Guilt	<input type="checkbox"/> Restlessness	<input type="checkbox"/> Suicidal plans	<input type="checkbox"/> Behavior problems	<input type="checkbox"/> Suicidal thoughts	<input type="checkbox"/> Nightmares	<input type="checkbox"/> Aggressive Behavior	<input type="checkbox"/> Harm towards self and/or others	<input type="checkbox"/> Anxiety		
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