LEGACY CENTER
19751 E. MAINSTREET SUITE 218 - PARKER CO 80138
PHONE: 303-841-4005 - FAX: 720-851-4890
INFO@LEGACYPARKER.COM - WWW.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:

	LCCC Office Use Only
Did the biological mother receive prenatal care during the (check the box that applies): First Trimester: □ Yes □ No Second Trimester: □ Yes □ No Third Trimester: □ Yes □ 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**

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	
Has your child ever been diagnosed with a mental health diagnosis? If yes, what? What provider gave the diagnosis?			
Has anyone (besides the current referring provider) ever recommended that your child receive an evaluation or assessment? If yes, who? Why was a recommendation made for an evaluation?			
Has your child ever received counseling in the past? If yes, from whom? When did your child receive counseling? _____Yes _____No How do you feel your child responded to the counseling services provided?			
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: Did your child receive a diagnosis? _____Yes _____No What recommendations were made as a result of the evaluation?			
Is your child currently receiving any alternative therapies (acupuncture, homeopathic, herbal, biofeedback, etc.)? If yes, please explain:			
Has your child received genetic testing? _____Yes _____No If no, has this even been recommended? If yes, what were the results?			

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)	

LCCC Office Use Only

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:

Method:	Frequency:	Consistency among caregivers?	Effectiveness	**LCCC Office Use Only**

Other Discipline Notes:	**LCCC Office Use Only**
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:

Name:	Gender:	Age:	Relationship to you:	**LCCC Office Use Only**

List any learning/educational problems in your family (immediate and extended):	**LCCC Office Use Only**
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?	

LCCC Office Use Only

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:	

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**
Current Concern #1: When did the problem begin: What have you tried that has not worked: What have you tried that has worked:	
Current Concern #2: When did the problem begin: What have you tried that has not worked: What have you tried that has worked:	
Current Concern #3: When did the problem begin: What have you tried that has not worked: What have you tried that has worked:	
What are your primary goals for seeking treatment for your child? 1. 2. 3.	
Is your child experiencing any of the following? ___ Sad or depressed ___ Loss of interest ___ Weight change ___ Change in eating habits or appetite ___ Too little sleep ___ Too much sleep ___ Worthlessness/Guilt ___ Suicidal plans ___ Suicidal thoughts ___ Aggressive Behavior ___ Anxiety ___ Energy loss ___ Concentration Difficulties ___ Impulsiveness ___ Hyperactive ___ Irritability ___ Angry or mad ___ Restlessness ___ Behavior problems ___ Nightmares ___ Harm towards self and/or others Anything else:	
What is your child's understanding of why he/she is coming to Legacy?	