

NORTH TEXAS COUNSELORS GROUP COUNSELING FORM
 please email form to jackie@ntxcounselors.com or fax to 972-236-0044

Child's Name: _____ Date of birth: _____ Age: _____
 Address: _____
 Parent's Names: _____ How many years married: _____
 Parent's email: _____
 Are parents(Married/Divorced):If divorced, name/number of other parent: _____
 Phone Number: _____ Emergency Contact: _____

Is your child in individual therapy? (Yes/No) With who? _____
 Who referred you to us? _____
 Does your child have a mental health diagnosis: _____

Circle any symptoms your child displays and list the number of times per week the symptom is displayed.

Anger	Anxiety/Phobias	Bed wetting	Acts out sexually
Conduct Problems	Controlling	Isolation	Day wetting
Defiance/discipline issues	Depression	Homicidal thoughts/actions	Disassociates
Drug/Alcohol Use	Tantrums	Lack of empathy	Lying
Phobias	Hyperactivity	Lack of motivation	Lethargy
Low self-esteem	Shy	Nightmares	Obsesses
Under/over eating	Peer Problems	Running away	Sleeplessness
School problems	Stealing	Headache/stomachache	Sad

How does your child do in school (Academically & behaviorally)?

How does your child handle anger?

Has the child experienced any significant loss? If yes, explain:

What do you view as your child's major strengths and positive traits?

What are your child's hobbies?

How does your child interact with peers?

By signing this form, I understand that I am committed to paying \$240 for the full group regardless if I am in attendance or not. I authorize my credit card on file to be charged a one time fee of \$240. **(Circle) Visa MC DISC**

X _____ X _____
 Signature Date

Credit Card # _____ Exp: _____ CVC: _____