

## *Orlando Family Counseling, Inc. (YOUTH)*

**PARENTS & FAMILY INFORAMTION:**

Marital Status: Married \_\_\_ Separated \_\_\_ Divorced \_\_\_  
 How long divorced \_\_\_\_\_ Number of divorces \_\_\_\_\_ Length of current marriage \_\_\_\_\_  
 Frequency of family moves in the last two years: \_\_\_\_\_; How long at the current address; \_\_\_\_\_

Please list OTHER children by age: (Place a check mark by name if from previous marriage or adoption)					
NAME	AGE	SEX	EDUCATION	LIVING AT HOME	SPECIAL CONCERNS
Please list any other person (s) living in your home:					
NAME	AGE	SEX	RELATIONSHIP	LIVING AT HOME	SPECIAL CONCERNS

**CLIENT'S HEALTH RATING:** Excellent \_\_\_ Good \_\_\_ Average \_\_\_ Poor \_\_\_ Very Poor

Currently under a doctor's care? \_\_\_ If yes, please explain. \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Current medication : \_\_\_\_\_

Has your child seen a counselor or therapist previously? If yes, who and when ? \_\_\_\_\_

What is your main concern about your child?

\_\_\_\_\_

\_\_\_\_\_

<b>ADDITIONAL BACKGROUND INFORMATION &amp; SPECIFIC CONCERNS ABOUT YOUR CHILD:</b>