Karma Counseling
Zahra Payravian, LPC

Karma Counseling LLC
4101 W.Spring Creek PKWY
Suite 100
Plano, TX 75024
(469) 939-7916
www.karmacounseling.net

CHILD INTAKE – ADDITIONAL INFORMATION

Welcome. We look forward to providing you with excellent and efficient counseling, psychotherapy or psychiatric services. Please take a few minutes to fill out this form. The information will help our providers better understand your situation as well as potential solutions in helping you get your life back on track.

Please note - the **information is confidential**, for our providers' use only, and will not be released to anyone without your written permission.

Additional Client Information:

Parent/Guardian Name(s) _____

□ Single □ Married □ Re-Married □ Divorced □ Widowed

If the rights of parent/guardian are determined by a court order, a copy of the most current legal custodial order is required prior to beginning services. Please indicate if this apples: □ Yes □ No

If parent is re-married, step-parent Name(s) _____

Is your home the child's primary residence? □ Yes □ No (If yes, you may skip the address line below.)

Street Address: _____ City/State: _____ Zip Code: _____

Is your child currently in counseling elsewhere? □ Yes □ No

If yes, please describe: _____

_____

Has your child ever received counseling or evaluation services? □ Yes □ No

If yes, please describe: _____

_____

Have you or your child ever been involved in any type of litigation? □ Yes □ No

If yes, please describe: _____

_____

Why are you seeking counseling? _____

_____

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Client Questionnaire

What questions do you have today?

What do you hope counseling services will provide?

Is there anything I need to know about your child before working with your child?

Please list your child's strengths:

Please list your child's struggles:

What concerns do you have for your child?

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Age _____ Grade _____ Failure or Held Back? _____

Current School _____

What do school personnel tell you about your child?

_____

_____

____

Grade	School	Avg. Grades	City	State
Pre-K				
K				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

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Relatives	Name	Age	Does the Child Get Along with This Person?	Occupation
Father				
Mother				
Sister(s)				
Brother(s)				
Step-Mother				
Step-Father				
Step-Sister(s)				
Step-Brother(s)				
Who lives in this child's home?				

About Your Child's Routine

What kinds of physical exercise does your child get?

_____

How much coffee, cola, tea, or other caffeine does your child consume each day?

_____

Is your child's eating restricted in any way? How? Why?

_____

Bedtime _____ Wake-up time _____

Hours of sleep on an average night? _____

Does your child have any problems getting enough sleep? Please describe fully.

_____

_____

_____

_____

_____

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About Your Child's Health

Who is your child's pediatrician? _____

When was the last visit? _____

Any concerns shared by the doctor?

_____

Describe any allergies your child has.

_____

List all medications or drugs your child takes or has taken in the last year—including prescribed and over-the-counter.

_____ _____

_____ _____

_____ _____

_____ _____

Starting with birth and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions your child has had.

_____

_____

_____

_____

Is there a history of mental illness in the child's family? If so, please explain.

_____

_____

Does any family member have a current or chronic illness? If so, please explain.

_____

_____

Anything else you are concerned about?

_____

_____

_____

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About Your Child's Symptoms

Please mark all of the items that apply to your child.
Feel free to add any others under "Any other characteristics."

- ☐ Accident-prone
- ☐ Affectionate
- ☐ Aggressive / Assaults
- ☐ Anxious / Nervous / Timid
- ☐ Argues / Defiant / Oppositional
- ☐ Breaks Rules / Law
- ☐ Bullied by Others
- ☐ Bullies / Bossy of Others
- ☐ Cheats
- ☐ Clowns Around
- ☐ Compliant
- ☐ Complains of Feeling Sick
- ☐ Conflicts at School
- ☐ Conflicts at Home
- ☐ Conflicts with Friends
- ☐ Conflicts with Authority
- ☐ Cruel to Animals
- ☐ Dawdles
- ☐ Dependent / Clingy
- ☐ Depressed / Sad
- ☐ Destructive
- ☐ Developmentally Delayed
- ☐ Difficulty w/ Parent(s) Partner
- ☐ Disorganized
- ☐ Distractible / Daydreams
- ☐ Disrupts Family Activities
- ☐ Drug or Alcohol Use
- ☐ Eating Issues (i.e. obese)
- ☐ Failure in School
- ☐ Fearful / Shy
- ☐ Feelings are Easily Hurt
- ☐ Fidgety
- ☐ Fights (gets into)
- ☐ Fire Setting
- ☐ Forgetful
- ☐ Hair Chewing
- ☐ Head Banging
- ☐ Hitting / Biting
- ☐ Hostile
- ☐ Hyperactive
- ☐ Hypochondriac
- ☐ Imaginary Playmates
- ☐ Immature
- ☐ Inappropriate Sexual Behaviors / Masturbation
- ☐ Inattentive
- ☐ Independent
- ☐ Inflicts Pain on Others
- ☐ Insults Others
- ☐ Interrupts
- ☐ Intimidated by Others
- ☐ Irritable
- ☐ Isolates / Withdraws
- ☐ Lacks Concern for Others
- ☐ Lacks Motivation / Procrastinates
- ☐ Lacks Respect for Authority
- ☐ Learning Disability
- ☐ Legal Difficulties
- ☐ Lethargic
- ☐ Likes to be Alone
- ☐ Loss of Friends
- ☐ Low Frustration Tolerance
- ☐ Lying / Manipulates
- ☐ Moody
- ☐ Mute / Refuses to Speak
- ☐ Nail Biting
- ☐ Needs Much Supervision
- ☐ Nightmares / Terrors
- ☐ Noisy
- ☐ Noncompliant
- ☐ Only Younger Playmates
- ☐ Outgoing
- ☐ Overactive
- ☐ Overly Obedient
- ☐ Over-sensitive / Cries Easily
- ☐ Picks on Others / Teases
- ☐ Pouts
- ☐ Refuses / Resists / Slow Responding
- ☐ Restless
- ☐ Rocking or Repetitive Movements
- ☐ Runs Away
- ☐ Self-harming Behaviors
- ☐ Sexualized Behavior
- ☐ Sexually Active
- ☐ Smokes
- ☐ Speech Difficulties
- ☐ Stealing
- ☐ Stubborn
- ☐ Suicide Talk or Attempt
- ☐ Swearing / Talks Back
- ☐ Temper Tantrums / Rages
- ☐ Tics – Movements or Noises
- ☐ Truancy
- ☐ Uncooperative
- ☐ Uncoordinated
- ☐ Under-active
- ☐ Unhappy
- ☐ Violent
- ☐ Wets Bed / Clothes

Any Other Characteristics? _____

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Mental Status Information

Have you or your child ever attempted suicide or harmed yourself in any way?

□ Yes □ No

Are you or your child currently thinking about suicide or harming yourself in any way?

□ Yes □ No

Have you or your child had any thoughts, even once, in the past, including the past few days or weeks, of suicide or harming yourself in any way?

□ Yes □ No

Are you or your child having any thoughts about harming anyone else in any way?

□ Yes □ No

STATEMENT OF UNDERSTANDING

I solemnly swear that all of the above information is true to the best of my knowledge.

Guardian's Signature Date