Parent's Application and Appraisal Form

Date__________________________

Patient's Name____Age_______________

Parent (s) Name____________________________________Phone___________________

Address____Zip________

Physician____Phone____________________

Adopted Child _____Yes _____No At what age________________________

Mother's Name_______________________Father's Name________________________

_____Natural _____Step _____Natural _____Step

_____Adoptive _____Foster _____Adoptive _____Foster

Age_____Education (Years)______ Age_____Education (Years)______

Marital status of of natural parents of child (check all that apply)

_____Married _____Living Together _____Mother Remarried

_____Not Married _____Separated _____Father Remarried

_____One Parent Deceased _____Divorced

Dates of Marriages From ____________ to ________________Number of years_______

Dates of Other Marriages From_________to ________________Number of years_____

Children: Please list all living and deceased (including patient) in order:

Name	Age	Birth date	Sex	School	Grade

Any other persons living in the home: ___yes ____no Who?

Name__________________________________Age______Relationship_____________

Mother's Health During Pregnancy ______Good ______Difficulties

______Anemia ______Weight Problems ______Accidents

______Toxemia ______Nausea/Vomiting ______Blood Pressure

______Diseases ______Unusual Physical Strain ______Urine Problems

______Bleeding ______Medication(s)_____________________________________

______Headaches ______Unusual Emotional Strain

______Poor Diet ______Other(Explain)____________________________________

Length of Labor ______Hours Forceps used? ______Yes ______ No

Birth Weight __________________ Number of Lost Pregnancies _____________

Complications During or After Delivery____

Was Alcohol, Drugs or Tobacco used during pregnancy?______Yes_____No

If so, please explain____

Who is/was closely involved in childcare besides mother/father up to age 5?
____

At what age did the child (patient) accomplish the following

______Sat Alone ______Walked Alone ______Toilet Trained
______Crawled ______Said Words ______Rode Bike (2 Wheels)
______Stood Alone ______Used Sentences

Are there current concerns with any of the following?

______Eating Problems ______Bed Wetting ______Masturbation
______Sleep Difficulties ______Wetting Pants ______Runaway
______Speech Difficulties ______Soiling Pants ______Temper Tantrums
______High Fevers ______Constipation ______Fire Setting
______Head Injuries ______Headaches ______Coordination
______Hospitalizations ______Avoids Being Held ______Other Concerns

Explain____

Is the child receiving medication? ____Yes ____No What/Doses?_________________
____

Drug Allergies?____
Current Health Problems?____
Current History of Significant Injury/Illness?__________________________________
____

Are other professional agencies involved? (SRS, Mental Health etc.)_________________
____

What is your child's difficulty and for how long?________________________________
____
____
____

Has the teacher/school indicated concern? If so,what?____________________________
____

Family history of:

______Alcoholism ______Retardation ______Drug Abuse
______Marital Problems ______Learning Problems ______Emotional Problems
______Suicide ______Other ___________________________________

What do you hope to gain from this referral to Heartland Rural Counseling Services, Inc.?____
____
____

Does the child have the following problems?

______Hurt Self or Others ______Low Self Esteem
______Shy ______Quiet and Withdrawn
______Dislikes School ______Hurts or Kills Pets/Animals

Indicate which characteristics your child definitely has:

____Selfish	____Sex Difficulties	____Untruthful	____Inadequate
____Impulsive	____Quick Tempered	____Unruly	____Sensitive
____Resentful	____Scatterbrained	____Cruel	____Affectionate
____Secretive	____Resents Authority	____Awkward	____Vain
____Quarrelsome	____Inconsiderate	____Won't Mind	____Obedient
____Doesn't Care	____Silly	____Emotional	____Stubborn
____Sassy	____Untidy	____Clean	____Moody
____Leader	____Follower	____Other____________________________	

Mother: Check the statements, which best describe your parenting style.

______ Too Strict	______ Too Demanding	______ Too Kind
______ Too Busy	______ Too Easy Going	______ Too Short Tempered
______ Too Lenient	______ Too Severe	______ Other ___________________

Father: Check the statements, which best describe your parenting style.

______ Too Strict	______ Too Demanding	______ Too Kind
______ Too Busy	______ Too Easy Going	______ Too Short Tempered
______ Too Lenient	______ Too Severe	______ Other ___________________

Briefly comment on your child's friends ____

____

____

Please add any other comments or concerns that may help us to understand your child.

____

____

____

Insurance Name ______________________________Group Number_________________

Parent Name with Insurance____

Parent Address____

____

Date of Birth of Insurance Card Holder_______________________________________

Parent Employer ____

Parent Social Security Number with Insurance_________________________________

I have been informed of the fee schedule for the counseling sessions I will be attending and understand I am responsible for payment on my account and will ensure payment is made.

____ _____________________

Signature of Parent or Guardian Date