

Lynne Logan Ph.D., L.M.F.T.



Phone: 412-999-8422

FAX: 724-327-7900

Email: drlynnelogan@yahoo.com

Website: www.drlynnelogan.com

ALL MAIL TO : 4889 William Penn Highway, Post Office Box #330,
Murrysville, PA 15668-2008

I am interested in an appointment in:

Upper St. Clair Office: _____ Murrysville Office: _____

CHILD/TEEN COUNSELING INTAKE

Child/Teen Full Name: _____

Male: _____ Female: _____ Age: _____ Birth Date _____ SS #: _____

Parents Names: _____

Address: _____ City: _____ State: _____ Zip: _____

School: _____ Grade: _____

BRIEF MEDICAL HISTORY:

Was child's birth and delivery normal? If no, please explain: _____

General Health: Excellent: _____ Good: _____ Fair: _____ Poor: _____ Height: _____ Weight: _____

Sleep Problems or nightmares? If yes, please explain: _____

Appetite or eating problems? If yes, please explain: _____

List Medications and reason for taking: -2-

List hospitalizations, surgeries, serious illnesses and child's age:

1. _____
2. _____
3. _____

SCHOOL HISTORY: Please check all that apply:

Poor Grades _____ Good Grades _____ Behavioral Problems _____ Uncooperative: _____ Attention
Issues _____ Social/Friend Problems _____ Gets Along Well with Others _____ Aggressive Behaviors
_____ Withdrawn _____ Lack of Follow Thru _____ Teacher Conflict _____ Gets Along with Teacher _____

Shows Leadership Ability _____ Favorite Subject _____ Separation Anxiety _____ Crying Spells _____
_____ Disruptive _____ Hyperactive _____ Shy _____ Outgoing _____

Does your child/teen seem to like school? If not, please explain: _____

Does your child/teen show any physical symptoms before or during school? _____ If yes, please
explain: _____

How often does it seem to happen? _____

Please list any school problems you are concerned about and when the problem started:

1. _____ 2. _____
3. _____ 4. _____

Your Child/Teen Hobbies: _____

Your Child/Teen Talents: _____

Does your child/teen have a pet (s): Explain: _____

FAMILY HISTORY:

Mother's Age _____ Health _____ Living with Child/Teen? _____ Please describe relationship with mother: _____

Father's Age _____ Health _____ Living with Child/Teen? _____ Please describe relationship with father: _____

Number of Siblings: _____ List Names and Ages and Describe Relationship with Child/Teen: _____

Are parents living together? _____ Divorced _____ age of child , _____ Separated _____ age of child _____, death of a parent _____ age of child _____.

If parents are divorced, what are the custody arrangements? _____

If joint custody, is other parent aware of you seeking counseling for your child/teen? _____

Step Parents: Age _____ Health _____ Relationship with child/teen _____

Any other persons living in the same household with child/teen? If yes, who? _____

Has there been any abuse in your child/teen's history? If yes, please explain _____

ABOUT YOUR CHILD/TEEN

Most of the time, my child/teen is: (check all that apply):

Happy ___ Joyful ___ Funny ___ Excited to participate ___ Eager ___ Cooperative ___ Attentive ___
Focused ___ Likes to learn new things ___ Loving ___ Kind ___ Empathetic to others ___ Loves
animals ___ Takes care of those smaller than him/her ___ Likes Outdoors ___ Shares ___ Tells the
truth ___ Sad ___ Depressed ___ Low Energy ___ Seems to be drawn to dangerous situations
___ Disruptive ___ Poor Grades ___ Uncooperative ___ Lacks Focus ___ Unkind ___ Mean to
Others ___ Has hard time sharing ___ Lies ___ Doesn't seem to laugh much ___ Is the Class
Clown ___ Finds school work difficult ___ Likes his friends ___ Has difficulty making friends ___
Curious ___ Rebellious ___ Listens and follows directions ___ Gets along well with others ___
Affectionate ___ Dislikes affection ___ Helpful ___ Others _____

How does your child/teen express his/her anger? Check all that apply: Yelling __ Outbursts of Temper ____
Kicking/Hitting____ Crying _____ Withdraws _____ Pouts _____ Picks on or teases other siblings____
Threatens other family members _____ Pretends not to be angry _____ Talks about it to you _____
Refuses your directives _____ Talks back _____ Destroys property _____ Ignores his/her feelings _____
Does not obey you _____ Other _____

Does your child/teen have any fears? If yes, please list and explain: _____

In your own words, how do you describe your child/teen's personality? _____

What do you see as three main strengths your child/teen has?

1. _____
2. _____
3. _____

Please list your three main concerns you have about your child/teen:

1. _____
2. _____
3. _____

What was the initial reason or the precipitating factor which caused you to seek counseling for your child/teen at this time? _____

Has you ever sought counseling for your child/teen previously? _____

If so, at what age, and for what reason? Length of time? _____

INSURANCE INFORMATION:

Insurance Information: Name of Insurance Co _____

Insurance ID # _____ Group # _____

Name of Subscriber _____ Subscriber's Birth Date _____

The above information was provided by: _____

Relationship to child/teen: _____

You were referred by? _____

I have read and signed the Consent for Treatment Agreement: _____

Print Name _____

Your Signature _____ Today's Date _____