APPLICATION/INTERVIEW

BROWARD SCHOOLS FAMILY COUNSELING PROGRAM

I. Data

STUDENT NAME (Last, First, MI)_____ Traffic #_____

Date of Birth_____ Age _____Sex_____Race/Ethnicity_____

Student's current address_____
(Street) (Apartment #) (City) (Zip)

Child currently lives with ☐ Parents ☐ Guardian ☐ Other_____ Custody _____

MOTHER /GUARDIAN_____Age___Home phone #_____

E-mail Address: _____Cell phone #_____

Employed by/Occupation_____Work hours_____Work phone #_____

FATHER /GUARDIAN_____Age___Home phone #_____

E-mail Address: _____Cell phone #_____

Employed by/Occupation_____Work hours_____Work phone #_____

Marital Status: ○MARRIED ○SINGLE ○SEPARATED ○DIVORCED ○COHAB ○RE-MARRIED ○WIDOWED

STEPMOTHER /OTHER_____Age___Home phone #_____

E-mail Address: _____Cell phone #_____

Employed by/Occupation_____Work hours_____Work phone #_____

STEPFATHER /OTHER_____Age___Home phone #_____

E-mail Address: _____Cell phone #_____

Employed by/Occupation_____Work hours_____Work phone #_____

Number of family members living in the home:_____**Number of children in the home:**____

OTHER FAMILY MEMBERS LIVING IN THE HOME (not listed above):

NAME	AGE / GRADE	RELATIONSHIP TO CHILD

Please check any of the following problem areas that may be affecting the family:

☐ Abandonment	☐ Divorce/separation	☐ Loss	☐ Parents can't control children
☐ Alcoholism/Addiction	☐ Domestic/Family Violence	☐ Medical Problems	☐ Poor communication
☐ Changes in routine	☐ Emotional problems	☐ Mental Illness	☐ Relocation
☐ Death in the family	☐ Financial problems	☐ Parents fight a lot	☐ Substance abuse

SCHOOL INFORMATION:

School Attending:_____ Grade: _____

Are you concerned about your child's ability to succeed in school? If so, please explain:

_____

_____

_____

_____

APPLICATION/INTERVIEW

APPLICATION FOR SERVICE (Cont'd, page 2) Traffic #_____

PLEASE CHECK ANY OF THE FOLLOWING THAT REPRESENT PAST OR PRESENT PROBLEMS FOR YOUR CHILD:

	Past	Pres		Past	Pres		Past	Pres
Aggressive			Immature			Reads below level		
Anxious			Impulsive			Self-mutilation		
Bedwetting/Soiling			Insecure			School avoidance		
Clumsy			Insomnia			Secretive		
Cries a lot			Jealous			Separation anxiety		
Daydreams			Lies			Sexually abused		
Defiant			Loses most things			Sexually inappropriate		
Depressed			Manipulative			Shy		
Destroys property			Moody			Sibling rivalry		
Disorganized			Nightmares			Skips school		
Disrespectful			No friends			Socially awkward		
Distractible			Obsessive/Compulsive			Steals		
Drug/pot/alcohol user			Over or under eats			Temper problem		
Easily frustrated			Phobias			Unmotivated		
Fearful			Poor grades			Withdrawn		
Hyperactive			Procrastinates			Won't sleep alone		

Does your child have any Medical Conditions? _____

_____

Medications (Current and History): _____

_____

Mental Health Hospitalizations: _____

What caused you to seek counseling at this time? _____

_____

How long has this been an issue?_____

How often does this issue impact healthy functioning within the family/school /or community?_____

_____

What have you done to resolve this issue?_____

_____

Please check strengths apparent in you and/ or your family:

☐ Communication	☐ Division of Responsibilities	☐ Commitment	☐ Security
☐ Togetherness	☐ Flexibility	☐ Forgiveness	☐ Trust
☐ Appreciation	☐ Affection/Love	☐ Shared Interests	☐ Warmth
☐ Encouragement	☐ Community/Family Ties	☐ Friendship	☐ Respect

Please list the 3 most important issues you would like to discuss throughout the course of counseling:

1. _____
2. _____
3. _____

I consent to counseling services and the establishment of a treatment plan specific to the needs of my child and/or family.

_____ _____

Signature of Parent/ Guardian Date