

Shannon S. Herman, MA
LICENSED PROFESSIONAL COUNSELOR
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www.ShannonHermanLPC.com

Intake Date: _____ Referred by: _____

Client Name: _____
Last: First: Middle:

DOB: _____ Age: _____ Male/Female

Parent Email Address: _____

Home Address: _____

City: _____ State: _____ Zip _____

Home Phone: _____ Alright to leave message: Y/N

Work Phone: _____ Alright to leave message: Y/N

Parent Cell Phone: _____ Alright to leave message: Y/N

Emergency Contact Name and #: _____

EDUCATION:

Enrolled in School: _____ Y/N

School Attending: _____ Grades: _____

Explain:

Diagnosis of Learning Difference: _____ Y/N

Dropout or withdrawal date: _____ GED: _____ Y/N

Ever repeated a grade or been held back: _____ Y/N

Suspended or Expelled: _____ Y/N

Please explain excess information on back:

FAMILY HISTORY

Who does the child live with? _____
Bio Mother's Name: _____ Occupation _____
Bio Father's Name: _____ Occupation _____
Step-Mother's Name: _____ Occupation _____
Step-Father's Name: _____ Occupation _____

If divorced, how often is the child between parents?

Brothers/Sisters Including step and half siblings, Include ages:

Have there been any recent deaths within the family? Close family members of friends?

MEDICAL HISTORY

Do you currently have any medical problems? Y/N
Explain: _____
Is your child taking prescribed medications? Y/N

Primary Care

Doctor _____
Name: Address City Zip
Phone# _____

Psychiatrist: _____
Name: Address City Zip
Phone # _____

Other Health Care Provider: (Dietitian etc.)
Name: Address City Zip
Phone # _____

Has your child ever been diagnosed with a neurological disorder, brain damage, or had a severe head injury?

COUNSELING

Has your child ever been to see a counselor before?

If so, when:

What was the counseling for?

Is your child currently seeing another therapist, other than myself? Y/N

What was your previous counselor's name?

Was it helpful?

Is there any history of sexual/physical abuse or neglect within the family or toward this child? When?

Have you or your child ever been in a treatment center for alcohol, drugs, depression, or an eating disorder?

What is the main problem(s) that you wish to have solved?

What are your expectations from counseling?

Please explain in detail the event that took place that triggered counseling:

How are other siblings handling this event?

As a parent, how are you handling this situation? Do you feel that you are handling it in a healthy way? Why or why not?

Is your child having a difficult time adjusting to a move, death, loss, or outside event that you have not mentioned?

Have you recently moved to this area? If you have had several moves within the last 5 years, please list a general timeline of where you have been, and why you have moved so frequently.

Please sign below if I may contact your child's primary care doctor with information that I am seeing your child, and give updates on his/her improvement.

I give Shannon Herman permission to contact regarding my child's health and diagnosis:

Doctor's name: _____

Parent's signature: _____