DATE ___________________

FRASER CENTER

CHILD/ADOLESCENT FACE SHEET

Please complete the following information to help us in thoroughly assessing your child for counseling services:

1. NAME____DOB_____________________

   ADDRESS____SS#______________________
   (Street)

   ____
   (City) (State) (Zip)

   GRADE IN SCHOOL_________ SCHOOL ATTENDING_______________________________

2. PARENT/GUARDIAN NAME ____

   ADDRESS (if different than above)____

   HOME PHONE _________________________WORK PHONE ________________________

   EMERGENCY CONTACT & PHONE ____

3. What are the average grades your child receives in school? ______________________________

   Has there been any recent change from the average? Do you have a recent progress report or report card? ________________________________

4. Is there a history of behavior problems in school? __________If yes please describe:

   ____

   ____

5. Has your child experienced any major change over the past year (i.e. move, death in the family, change of school)? ____

6. Has your child's personality changed dramatically? _____________________________________

7. Has your child ever been physically, verbally, sexually, or emotionally abused? ______________

8. Please describe the eating and sleeping habits of your child:

   ____

   ____

9. Date of last physical exam and results ____

   ____

10. Has your child ever been arrested or involved with the legal system? _______________________

OVER

11. Has your child previously been in counseling? ________If yes, please explain:

____

12. Briefly describe the reason for seeking counseling at this time:

____

____

13. Please include any additional information that would be significant regarding your child:

____

____

CONFIDENTIALITY STATEMENT

It is the policy of FRASER CENTER to keep all information, including client identity, strictly confidential; however, should the counselor or staff feel there is or will be a potential for personal harm, abuse to or by the child, or homicidal threats, such information will be forwarded to the proper agencies for action.

CONSENT FOR TREATMENT AND ASSESSMENT OF MINORS

This is to certify that I give permission to FRASER CENTER's counselor to treat my child.

This treatment may include individual or group psychotherapy, counseling, and testing. This treatment may include consultations other associates of this institution.

This treatment may also include referrals to other appropriate state and county or professional agencies for further counseling.

____ ________________________

Signature of Parent/Guardian Date

____ ________________________

Witness Date

OVER