TANNER
EMPLOYEE ASSISTANCE PROGRAM

To be completed by the parent or medical legal guardian requesting services for a minor child

Background Information:

Name of Child:_____ Age _____ DOB _____Race _____

Name of person(s) child resides with _____

Relationship to Child: Biological Parent - Parent & Step Parent - Grandparent - Other

Residing Address:_____City_____State_____Zip_____

Mailing Address:_____City_____State_____Zip_____

Home Telephone # _____ Work _____Cell _____

Emergency Contact – Name _____ Number _____ Relationship_____

If parents are separated or divorced, for how long? _____ Who has custody? _____

Other Biological Parent – Name_____

Referral Source: _____

School Name: _____ Grade _____

Primary Physician: _____ Tel # _____

Immediate Family Members: Names Age(s) ✓ if lives with client

Brother(s) _____

Sister (s) _____

Other _____

In your own words, briefly describe the main problem which prompted you to seek counseling for your child:

_____

_____

_____

_____

Problem areas: In the following list place a check mark✓ next to each item which identifies an area of concern to you. Place two checks✓✓ by those items, which are most important.

___Anger/temper ___Sexual Concerns ___ Depression

___Thoughts of Suicide ___ Educational/ School work ___ Unhappy most of the time

___ Family Problems ___Use of Alcohol ___ Fearfulness/ Phobia

___ Use of Tobacco ___Physical Problems ___ Excessive Caffeine

___ Work ___ Worry ___Marital Problems

___ Divorce ___ Stress ___Religious/ Spiritual Concerns

___ Insecure/Timid/ Lack of Self Confidence ___Traumatic Stress

___Problems with accepting discipline ___Current substance use:___ Marijuana ___Narcotics

___Amphetamines ___Methamphetamines ___Acid ___ Cocaine ___Alcohol ___Prescription

___Cigarettes ___ Other ***If checked, frequency of use:***

_____

Has your child ever been the victim of or witnessed any type of traumatic incident? If yes, please explain:_____

Medical History

List sicknesses, operations, and injuries. Indicate age when occurred and describe briefly.

_____

_____

Has there been any previous counseling or psychological, psychiatric, neurological, or EEG evaluations? If so, please list names, addresses and dates of contact.

_____

Indicate any continuing medication treatment. _____

When did the child last have a physical examination? _____

Name and address of Physician:

_____

Describe and developmental problems (such as walking and talking) : _____
_____

Describe and method of discipline used and how the child reacts to such discipline. _____
_____

Describe the child's appetite and eating habits currently: _____
_____

Describe nervous habits such as thumb sucking, nail biting, etc: _____
_____

Describe child's sleeping pattern now. Are there nightmare or night terrors now or in the past? _____
_____

Describe the child's level of activity and vigor. _____

Describe any problems in attention or sitting still._____

Food or Drug Allergies? _____

Any Moodiness? _____

Academic / School Information

Name of school_____Grade_____

Has child ever repeated a grade? _____ If so, when? _____

Describe what the child likes to do for fun, special interest, hobbies, etc: _____
_____

Please add any additional comments which you wish to tell your counselor: _____

Parent/Guardian Name: _____

Relationship _____

Date _____