

# Family Friend, LLC

## Registration Form

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### *Client Information*

#### Client's Name

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First Name	Middle Name	Last Name	Nickname
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#### Client's Date of Birth

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Month	Day	Year	Client's Age	Male	Female
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### *1<sup>st</sup> Parent/Guardian Information*

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#### Parent/Guardian Name

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Prefix	First Name	Middle Name	Last Name
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Is this your biological child?     Yes     No

Is this person financially responsible for the client?     Yes     No

Are you the primary parent?     Yes     No

Do you have legal custody of the minor child?     Yes     No

***Mailing Address***

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Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Email Address \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Cell Phone Number \_\_\_\_\_

Employer \_\_\_\_\_

***2<sup>nd</sup> Parent/Guardian Information***

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Parent/Guardian Name

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Prefix \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_

Is this your biological child? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is this person financially responsible for the client? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are you the primary parent? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you have legal custody of the minor child? \_\_\_\_\_ Yes \_\_\_\_\_ No

***Mailing Address***

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Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Email Address \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Cell Phone Number \_\_\_\_\_

Employer \_\_\_\_\_

***Family Information and Client History***

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**What concerns have prompted this appointment? Please include behavioral, academic, and emotional concerns.**

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**What is the history of these concerns? How long have they existed? Have any other concerns led to this point?**

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**Who resides in your home? Please list each person and their relationship to the client. If shared custody, please list members of both homes.**

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Does the client have an Individualized Education Plan (IEP) \_\_\_\_ Yes \_\_\_\_ No

Does the client have a 504 Plan? \_\_\_\_ Yes \_\_\_\_ No

Describe any suspensions or expulsions from school, including reasons.

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What are the client's interests/hobbies/sports/ extracurricular activities?

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**Health Concerns**

Has the client ever been placed in a residential program or hospital? \_\_\_\_ Yes \_\_\_\_ No

If your answer was yes to the question above please note what residential placements or hospitals have been utilized? Please list below.

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**Please describe any concerns with substance abuse. Please include details regarding which substances and time frame of use.**

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**Please describe any family history of mental illness or substance abuse issues.**

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**Please list any medications the client is currently taking, medical reason for taking the medication and the dosage amount currently.**

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Does your child display any unusual or atypical behaviors, responses, or sensitivities in any of the following areas?

Taste \_\_\_\_\_

Smell \_\_\_\_\_

Movement \_\_\_\_\_

Touch/Texture Issue \_\_\_\_\_

Auditory \_\_\_\_\_

Other \_\_\_\_\_

### **Emotional Adjustment**

Do you consider any of the following to be a problem for your child at this time? (check all that apply)

Fidgets, is easily distracted, has a hard time staying seated, has difficulty waiting for his/her turn

Talks excessively, interrupts often, doesn't listen

Is often depressed/irritable mood

Low energy/fatigue

Shy

Often loses things, very disorganized compared to others of his/her age

Poor concentration

Difficulty initiating tasks

Difficulty completing tasks

Difficulty following instructions

Engage in impulsive behaviors

Immature compared to same aged peers

Engage in physically dangerous behaviors

Often argumentative with adults

Often actively defiant to adult requests and rules



- Often deliberately does things to annoy others
- Blames others for his/her mistakes
- Often angry or resentful
- Somatic complaints of not feeling well
- Excessive separation difficulties
- Easily frustrated
- Lies
- Steals
- Feeling of worthlessness or low self esteem
- Withdrawn
- Overly anxious or fearful
- Sleeping too little/insomnia
- Sleeping too much
- Difficulty making decisions
- Cries easily
- Temper Tantrums
- Rapid mood changes/mood swings
- Suicidal thoughts
- Aggressive towards others  Peers or  Adults
- Poor appetite
- Overeats
- Explosive temper with minimal provocation
- Odd fascinations
- Unrealistic worry about future events
- Excessive need for reassurance
- Substance Abuse  drug  alcohol
- Affectionate

- Argues talks back, smart-alecky, defiant
- Cheats
- Cruel to animals
- Procrastinates, wastes time
- Developmental Delays
- Disrupts family activities
- Dropping out/not attending school
- Drug or Alcohol use
- Failure in school
- Fighting, hitting, violent, aggressive, hostile, threatens, destructive  home  school
- Sets Fires
- Friendly, outgoing, social
- Interrupts, talks out, yells
- Learning disability
- Nightmares
- Likes to be alone
- Mute, refuses to speak
- Need for high degree of supervision at home over play/chores/schedule
- Recent move, new school, loss of friends
- Responsible
- Self Harming behaviors (biting, hitting, cutting, head banging, scratching self)
- Suicide talk or attempt
- Temper tantrums, raging
- Truant, school avoiding
- Appears depressed or down
- Erratic Mood changes

Please give details to any information above that you feel needs further explanation.

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***Unusual or Atypical Behaviors***

Does your child display any of the following behaviors? (check all that apply)

Preoccupation with specific subjects, topics, or objects that is atypical in intensity or focus

Eccentric forms of behavior

Lack of awareness or sensitivity to the need or feelings of others

Facial expression or emotional responses that are not appropriate to or consistent with the circumstances

Need or desire to do things in a very specific way or order, or rituals that must be followed

Mannerisms or odd ways of moving his/her body

Self-injury or physical aggression towards others

Difficulty understanding jokes or humor

Difficulty adjusting to new surroundings

Difficulty adjusting to change in plans or routines

**Social Skills Information**

**How does your child get along with adults at home?**

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**How does your child get along with peers?**

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**How does your child get along with siblings or other children in the home?**

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**Describe your child's friendships.**

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**What are your child's social strengths? Weaknesses?**

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**What are your child's behavioral strengths? Weaknesses?**

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**Has your child been involved in any of the following? (Please check all that apply)**

- Educational Services from private entity such as tutoring, private school etc.
- Therapy services from private entity (speech, occupational, physical therapy or private counseling)
- Dept. of Children's Services
- Juvenile Court System or Probation
- Hospitalization
- Evaluation from a private entity (ex. Psychological, academic, educational, mental health, behavioral, etc)

**If any other services have been utilized that are not listed above please describe below.**

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**List all major diseases, illnesses, important accidents or injuries, hospitalizations, periods of loss of consciousness, head injuries, chronic illnesses, seizure disorders, and any other medical condition your child has experienced including pregnancies. Please explain in detail.**

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**List three strong or favorite qualities or characteristics of your child.**

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**List three of the most challenging qualities or characteristics of your child.**

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**What has been your primary disciplinary method with this child?**

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**How does the child respond?**

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**Is spirituality based therapy a priority in your home/family in terms of therapy?**

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**If there is any other pertinent information that may be relevant in the evaluation of your child please note below.**

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**Have you ever worked with a therapeutic or educational consultant? \_\_\_\_\_ Yes \_\_\_\_\_ No**

**If you have worked with another consultant and are comfortable listing the consultants name or business name please do so below.**

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**Where did you hear about Family Friend Therapeutic and Educational Consulting?**

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