

**Shannon S. Herman, MA**  
**LICENSED PROFESSIONAL COUNSELOR**  
**(214) 837-0457 ❖ ShannonLPC@charter.net**  
**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?

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If so, when:

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What was the counseling for?

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

What was your previous counselor's name?

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Was it helpful?

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

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

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

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What are your expectations from counseling?

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

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How are other siblings handling this event?

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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?

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

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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.

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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: \_\_\_\_\_