learning community charter school

School Based Counseling Program

Intake and Referral Form

I. General Background

What is your primary concern / reason for the referral?

___

As the parent or guardian, what goal or outcome do you wish from counseling?:

___

Who lives at home with the student?:

Guardian:______________________ Natural Parent Foster Step Adoptive Other

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Other Family Members in the home:

Name:______________________ Age:_______ Sex: M F Relation: ______________

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Name:______________________ Age:_______ Sex: M F Relation: ______________

If applicable, is the non-custodial parent involved (if he/she does not reside in the home)?

Y N

Amount of time spent per week with non-custodial parent: ______________________

II. Student's Medical and Counseling History

Does the student have any current health problems?:

___

Is the student taking any medications (if "yes", list the medication)?:

___

___

Reason the medication was prescribed?:

___

How does the medication affect behavior (sleep, appetite, mood, attention, hyperactivity, etc.)?:

___

Is the student currently receiving or have they received counseling services in the past?:

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If "yes", with whom?:

Are there any emotional concerns that run in the family (anxiety, depression, bi-polar, ADHD, etc.)?,

please list:

III. Student's Behavioral History

Does the student have any sleep concerns (nightmares, trouble falling or staying asleep, etc.)?

In your opinion, how is the student's school performance?:

Does the student have any behavioral concerns in the home?:

Does the student display any aggressive behaviors (list type)?:

Has the student experienced any traumatic events such as a death in the family, divorce, violence, traumatic accident, etc.?:

Office Use Only: PSC: _________ **Date Received: ____________** **Start of Services: _________**

End of Services:___________