Wendy K. Berger, MA, LPC
Transformational Counseling and NET for Adults and Children

CONFLUENCE WELLNESS CENTER, PC
1776 South Jackson St., Ste. 418, Denver, CO 80210 • 303-394-4204 • www.confluencewellness.com

Client Name: _____ Date of Birth: _____

Grade at school: _____ Child lives with _____ since _____

Who referred you to our office? _____

If divorced who has custody? _____joint _____sole _____other _____

Mother's Name: _____

Father's Name: _____

Step Mother: _____ Name child uses for her: _____

Step-Father: _____Name child uses for him: _____

Address: _____Telephone: _____

Email for both parents _____

Are there any cultural or spiritual factors that are significant? _____

_____

Please list all siblings in order of their birth. Next to their names indicate ages:

_____

Present Health Concerns: _____

Medications: _____

Have you had previous counseling and was it helpful? _____

Trauma History: Please list any significant traumas, and the age at which they occurred, such as surgeries, serious illness, accidents, fractures, stressful events, such as death of family members, moving, divorce, etc.

_____

_____

_____

_____

_____

What brings you in today? _____

_____

_____

How will you know that the problem is solved? _____

_____

Is there anything else I should know? _____

_____

Please have your child either draw a picture or write a statement on a separate sheet of paper about his/her perspective of the situation.