Anna Cross MEd, LPC
Individual and Family Therapy

Welcome to the practice of Anna Cross, MEd, LPC. Please complete the forms as accurately and completely as possible before your first appointment. Doing so will maximize our time together. We can review any questions you may have during your first session.

Child Information

Date: _____ Therapist's name: Anna Cross, MEd, LPC_____

Client's Name: _____

Age:_____ Date of Birth:_____

Home Address:_____

City: _____ State: _____ Zip: _____

Mailing Address (if different from home):

_____

City: _____ State: _____ Zip:_____

Parent Contact Information:

Home Phone: _____ OK to Leave a Message? Y N

Work Phone: _____ OK to Leave a Message? Y N

Cell Phone: _____ OK to Leave a Message? Y N

Email: _____OK to Send a Message? Y N

Insurance Co: _____ Insurance Phone:_____

Subscriber ID: _____ Group #:_____

Name of Insured:_____D.O.B_____ Relationship: _____

Insured's
Address:_____Employer_____

3400 Bissonnet
Ste. 270
Houston TX 77005

Phone 713.582.5981
Fax 855.570.2235
anna@acrosstherapy.com

18700 W. Lake Houston
Pkwy. Ste.102
Humble TX 77346

I authorize Anna Cross, MEd, LPC to contact the person listed below in case of an emergency:

Name:_____ Number:_____

Social History:
Parents (Including stepparents if applicable):

Name	Occupation	Hrs/Wk	Age	Relation to Child

Please list other siblings and/or other household members

Name	Age	Lives at home	Relation to Child

If applicable, who has legal/physical custody of child?_____
(Please provide legal documentation)

If a biological parent is absent from the household, describe frequency and type of visitation.

_____

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Is the child, either directly or indirectly, currently involved in any legal dispute such as child custody? If yes, please elaborate:

_____

Education:

Where does your child attend school?_____Grade_____

What are his/her typical grades? _____

What are your child's academic strengths?_____

Academic weaknesses?_____

Has there been a change in your child's performance at school? Yes No

If yes, please describe:_____

Has your child received IQ or Academic testing? Yes No

Does or has your child participated in any of the following?

Yes No Resource (for which classes/how many hours?)
Yes No GT, Accelerated or Honors programs
Yes No 504 Plan, explain: _____
Yes No Individual Education Plan (IEP), explain: _____

Has your child had problems with any of the following?

Yes No Frequent moves necessitating change in school
Yes No Truancy, explain: _____
Yes No Fights, explain: _____
Yes No Absenteeism, explain: _____
Yes No Detention, explain: _____
Yes No Suspension, explain: _____
Yes No School refusal, explain: _____
Yes No Underachievement, explain: _____

Presenting Problem:

What prompted you to seek counseling for your child?

_____

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How long has this been a significant concern for your child? When did you first notice this problem?

_____

How has this problem affected your child?

At home:_____

At school/work:_____Community:_____

Please mark all of the items that apply to your child on this list. Feel free to add any others at the end under "Other."

- ☐ Affectionate
- ☐ Angry/Irritable Mood
- ☐ Cruel to animals
- ☐ Conflict with authority figures
- ☐ Complains
- ☐ Dawdles, procrastinates
- ☐ Difficulty Paying Attention
- ☐ Disrupts family activities
- ☐ Problems organizing tasks
- ☐ Vindictive/Spiteful
- ☐ Easily distracted
- ☐ Problems with sleep
- ☐ Obesity
- ☐ Weight loss
- ☐ Friendly, outgoing, social
- ☐ Disruptive or risky behavior
- ☐ Neglected appearance
- ☐ Interrupts, talks out, yells
- ☐ Responsible
- ☐ Runs away
- ☐ Specific phobia
- ☐ Insomnia or sleeping too much
- ☐ Temper tantrums, rages
- ☐ Avoiding normal social activities
- ☐ Teased, victimized, bullied
- ☐ Uncoordinated, accident—prone
- ☐ Argumentative and defiant behavior
- ☐ Bullies/intimidates others
- ☐ Concern for others
- ☐ Refuses to follow rules
- ☐ Feelings easily hurt
- ☐ Dependent, immature
- ☐ Frequently daydreaming
- ☐ Problems with following instructions
- ☐ Frequently forgetful/loses needed item
- ☐ Frequently fails to finish tasks
- ☐ Fidgets/Squirms
- ☐ Need for high degree of supervision
- ☐ Appetite increase/decrease
- ☐ Drug or alcohol use
- ☐ Fire setting
- ☐ Independent
- ☐ Fearful/excessive worry
- ☐ Imaginary playmates, fantasy
- ☐ Rocking or other repetitive movements
- ☐ Sad, unhappy
- ☐ Suicide talk or attempts
- ☐ Tiredness and loss of energy
- ☐ Hair pulling/skin picking
- ☐ Shyness or discomfort in certain
- ☐ Sudden feelings of intense anxiety/fear
- ☐ Wetting or soiling in the bed or clothes
- ☐ Hypochondriac, always complains of feelings sick
- ☐ Having a sense of impending danger, panic or doom

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☐ Loss of interest in, or conflict with, family and friends
☐ Feelings of worthlessness, guilt, fixation on past failures or exaggerated self-blame or self-criticism
☐ Obsessions are repeated, persistent and unwanted urges or images that cause distress or anxiety
☐ Compulsions are repetitive behaviors that you feel driven to perform
☐ Loss of interest or pleasure in normal activities
☐ Sexual—sexual preoccupation, public masturbation inappropriate sexual behaviors
☐ Extreme sensitivity to rejection or failure, and the need for excessive reassurance
☐ Tics-involuntary rapid movements, noises, or word productions

Other: _____

Have your child ever intentionally self-harmed?_____

Attempted suicide?_____

Harmed others?_____

Peers:
Does your child have quality relationships with other children?

Yes No If no, please explain: _____

Psychiatric and Medical History:
Please list any psychiatric hospitalizations, residential, or day treatment programs (including any alcohol and drug treatment programs).

Diagnosis	Length of Stay	Treatment	Response

Please list any current or prior outpatient psychiatrists and therapists you have seen.

Name	Title	Location	How Long

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Please list current **psychiatric** medications. Please attach a separate sheet if you need to list additional medication.

Name	Dosage	Duration	Response

Please list current **non-psychiatric** medications.

Name	Dosage	Duration	Response

Please describe any significant medical illnesses or diagnoses:

_____

I authorize Anna Cross, MEd, LPC to contact my primary care physician (PCP) to notify and coordinate care. _____ Yes _____ No _____NA

Doctor Name: _____ Phone:_____

2. I authorize Anna Cross, MEd, LPC to notify my psychiatrist to notify and coordinate care. _____ Yes _____ No _____NA

Doctor Name: _____ Phone:_____

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Personal Abuse History:
Has your child ever been the victim of abuse or neglect? Yes No
If yes, what was the nature of the abuse? (Please circle all that apply.)

Physical Emotional Neglect Sexual Witnessing violence

Other:_____

Are you struggling with your marital relationship or parenting?

Yes or No If yes, please describe:_____

Has your child ever been involved with the following:
Yes No Child Protective Services
Yes No Probation/Juvenile Probation/Detention
If you answered yes to any of the above please explain:_____

_____

Other:
What type of faith (if any) does your family follow?

_____

What are your child's favorite activities?

_____

Who can your child or family count on for support?

_____

In the past, what has been helpful in dealing with child/family issues?

_____

Client Signature:_____ Date:_____

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Acknowledgement and Consent

By signing this form:
(1) I acknowledge that I have been given a chance to review and ask questions about the Informed Consent and Practice Policies and Practices to Protect the Privacy of Your Health Information.
(2) I understand and agree to the stated practice polices as listed above and
(3) I give full consent for my minor child, or myself

_____, to participate in counseling.
(Print Client Name)

I certify that I have the legal right to seek and authorize treatment for my minor child or myself.

_____ _____
Client Signature (or parent/guardian if client is a minor) Date

_____
Print Name

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