Jean L. Hehn, LCSW
Child, Adolescent, Adult, Family Therapy

Suite 6
1003 S. Alexander Street
Plant City, Florida 33563

Telephone: 813-763-1833

Child/Teen's Name____ Age_____ Date of Birth__________

Sex_________ Today's Date______________________________

Mother's Name (or Female Head of Household) ____

Father's Name (or Male Head of Household) ____

Does child live with? Both Parents_______ Mother_______ Father_______ Other______________

Home Address: Street____

City___________________State______________Zip_____________________

Home Phone___________________________ May we leave a message there? Yes___ No____

Mother's work phone________________________ Mother's Cell Phone_________________________

Father's work phone ________________________ Father's Cell Phone _________________________

Parent's Social Security number if using insurance____

What is the main reason you are seeking assistance at this time?__________________________________

____

Who referred you to Jean Hehn?____

If you would like to receive occasional (2-3x per year) information of interest to parents and families, please give your email address here:____

School Information

School Attending____Grade____________

Any special programs (SLD, Speech, Gifted, EH, etc.)?______________________________________

Was your child evaluated by a school psychologist?__________ if so, when?_____________________

Are there any behavior concerns at school (suspensions, expulsions, office referrals, etc.)___________

____

Special activities enjoyed at school____

Interests outside of school____

Developmental and Medical Information

Anything unusual about your child's birth (low birth weight, long labor, fetal distress, etc.)? ________

____

____

Were there any difficulties with your child meeting developmental milestones (sitting up, crawling, walking, talking, etc.)? ____

____

Difficulties toilet training?____

Is your child now experiencing any toileting difficulties (bed wetting, bowel control, etc)?____________

____

Is your child sensitive to touch, taste, sounds, or light?____

Please describe your child's current physical health: Excellent____ Good_____ Fair_____ Poor______

Physician's name and address____

Physician's phone number_____________________________

Is your child currently being treated for any medical condition? Please describe_____________________

____

Does your child currently take any medication? If so, please list _________________________________

____

Has your child had any surgeries? Please describe. ____

____

Has your child had any accidents or traumatic physical events (broken bones, car accidents, severe lacerations, head injury, sutures, etc.)?____

____

Has your child witnessed any traumatic events (other people being injured, etc)?_____________________

____

Does your child have any known history of sexual, physical or emotional abuse?_____________________

Family and Social Information

Was your child adopted? If so, at what age and from what country.________________________________

____

Do you have concerns that your child may be abusing alcohol or drugs or engaging in any other illegal activities? ____

____

Do family members have any difficulty with alcohol or drugs?____________________________________

____

Has your child seen a counselor or therapist before? ____

____

Is there a family history of mental health concerns (depression, anxiety, bi-polar, etc.)?_________________

____

Please list the names of everyone living in the household:

Name	DOB	Education Level	Relationship to Child/Teen

Updated 09/01/06