



Andover Wellness and Counseling  
853 Turnpike Street 2<sup>nd</sup> Floor  
North Andover, MA 01845  
Phone: 978-417-1531  
Email: papadinis.rebecca@gmail.com

## Child Anxiety and Self-Esteem Group

This form may seem long, but the information on it will help me to better understand you. The information on this form is confidential unless it has to do with hurting yourself or someone else.

### Child Demographic Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Gender: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home phone: \_\_\_\_\_ Is it okay to leave a message: yes/no (please circle one)

Client Cell Phone: \_\_\_\_\_ Is it okay to leave a message: yes/no (please circle one)

Parent Cell Phone: \_\_\_\_\_ Is it okay to leave a message: yes/no (please circle one)

Parents or Legal Guardians: \_\_\_\_\_

With whom does your child live? \_\_\_\_\_

How did you hear about the group? \_\_\_\_\_



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What school do you attend? \_\_\_\_\_ Grade: \_\_\_\_\_

Does your child like attending this school? Are they having any difficulties? If so briefly explain.

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What are your child's interests or hobbies?

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**Assessment:**

Please check any/all of the symptoms that your child is having

Depression		Feeling hopeless	
Extreme sadness		Problems getting along with family	
Trouble concentrating		Change in sleeping habits	
Memory Problems		Lack of energy	
Change in eating habits		Weight changes	
Extreme happiness		Feeling tearful	
Trouble going to school		Problems getting along with friends	
Lack of enjoyment in usual activities		Feeling stressed	
Obsessions/Compulsions		Feeling worried or anxious	
Easily irritated		Feeling fearful	
Feeling Guilty		Physical complaints of pain	
Problems with anger		Sudden feelings of panic	
Unusual dreams/poor sleep		Muscle tension	
Drug or alcohol use		Acting violent	
Thoughts of hurting yourself or others		Thoughts of killing yourself or others	
History of self-harming behavior		Active self-harming behavior	



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Does your child currently see a therapist? (Yes/No) If so, what is their name?

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Has your child been diagnosed with a mental health disorder? If so, which one(s)?

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**History:**

Has your child ever experience any critical events or an event that you consider traumatic?

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If so have you sought help for this, or does it continue to cause you distress at this time?

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**Expectations:**

What would you like to get out of this group?

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What else would you like for me to know at this time?

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**Parents:**

Please feel free to add anything you wish below (additional information you would like me to know, goals, concerns etc.)

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Thank you for taking the time to complete this form. This information will be very helpful to me so as I can best support you/your child.