Wings of Eagles Counseling Clinic

To nurture a partnership of hope, health and wholeness in all people using solution focused and evidenced bases practices

Initial Client Questionnaire

Case Manager Name: ____

Contact Information: ____

Client Demographics:

Client Name: ____________________________ DOB: ___________ Age: _____

Race: __________ Gender: __________

Address: _____________________________________ Phone: _____________

Client lives with. ______________________ Who has legal custody? ___________

Parent/Guardian (if different from above)

Name: ______________________________ Phone: ______________________
Are biological parents involved in the case? Yes No
If not, when was the last contact? _______________________________________
Will there be reunification? Yes No

Referral Information:

Why is the client being referred? Please list recovery goals.

What services are needed to help with recovery goals? (service level and number of hours)

What is the client's mental health diagnosis and symptoms?

217 N Madison Street, Green Bay WI 54301
Phone: 920-227-7078 Fax: 920-273-8847 www.wingsofeagles1.com

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Presenting Problem:
Check ALL that apply or have applied in the past to your child. List the frequency and severity of the problem (e.g. anger outbursts 3x each day, throwing things, hitting and/or swearing). If the problem is no longer present, then indicate when stopped.

Sleep Problems	Sleeping too little	Trouble falling asleep	Frequent nightmares
Sleeping too much	Trouble staying asleep	Eats too much/too little	Dieting when not needed
Child or Parent concerned about child's weight/body image	Suicide threats, attempts or thoughts	Significant loss/death of someone	Feeling weepy or crying frequently
Low Self-Esteem	Indecisive	Irritable	Unable to care for self
Loss of Interest	Lack of Energy	Withdrawn	Mood Swings
Self-Harmful	Impulsiveness	Hyperactivity/Agitation	Poor/short attention span
Anger/Temper Outbursts	Verbal Aggression	Threats to harm/kill others	Swearing
Difficulty forming close relationships		Other Verbally Aggressive Behavior:	
Frequent Lying	Stealing or Shoplifting	Running Away	Yelling
Anxiety/Fears/Phobias/Worries	Obsessive-Compulsive Traits	Perfectionist	Other:
Physical Aggression (describe behaviors, to whom, and how often)			
Oppositional and/or argumentative (refusal to follow directives, arguing)			
Peer Group problems (negative or delinquent friends, easily influenced, fighting, none or few friends)			

Is the client taking medication? Please list

Please list any other pertinent information that will help with proving services that is not listed on care plan.

Please send to referrals@wingsofeagles1.com along with care plan and ROI