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CLIENT INFORMATION
Child/Adolescent

Please provide the following information for your child and answer the questions below.

Please note: Information you provide here is protected as confidential information.

BRING THIS FORM TO YOUR CHILD'S FIRST SESSION.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Child's Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: (_____)_____ May we leave a message? □ Yes □ No

Cell/Other Phone: (_____)_____ May we leave a message? □ Yes □ No
May we send a text message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
***Please note: Texting and Email correspondence are not considered to be a confidential forms of communication**.

Other contact(s): _____

Referred by (if any): _____

Has your child previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No
□ Yes, previous therapist/practitioner: _____
For how long? _____
What was the outcome? _____

Is your child currently taking any prescription medication?

□ No
□ Yes

If yes, please list: _____

Has your child ever been prescribed psychiatric medication?

□ No
□ Yes
If yes, please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your child's current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems he/she is currently experiencing:

_____

2. How would you rate your child's current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems he/she is currently experiencing:

_____

3. How many times per week does your child generally exercise? _____

What types of exercise does your child participate in?_____

4. Please list any difficulties your child experiences with his/her appetite or eating patterns:

_____

5. Is your child currently experiencing overwhelming sadness, grief or depression?

□ No
□ Yes
If yes, for approximately how long? _____

6. Is your child currently experiencing anxiety, panic attacks or have any phobias?

□ No
□ Yes
If yes, please describe: _____

When did he/she begin experiencing this? _____

7. Is your child currently experiencing any chronic pain?
   □ No
   □ Yes
   If yes, please describe _____

8. What significant life changes or stressful events has your child or your family experienced?
   Please Indicate when the event(s) occurred (Example: 3 months ago, 9 years old, etc.)

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's **relationship to your child** in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
ADD/ADHD	yes/no	
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Bipolar Disorder	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Does your child enjoy his/her school? Is there anything stressful about his/her current school situation?

_____

_____

2. Do you consider your family to be spiritual or religious? □ No □ Yes

   If yes, describe your faith or belief: _____

3. What do you consider to be some of your child's strengths?

_____

_____

4. What do you consider to be some areas of improvement for your child?

_____

_____

5. What would you like your child to accomplish from therapy?

_____

_____

_____

6. Is your child currently having thoughts of hurting himself/herself or someone else? _____

If yes, please describe: _____

_____

_____

_____ _____ _____

Signature of person completing form *Relationship* *Date*