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CLIENT INFORMATION FORM FOR CHILDREN/ADOLESCENTS

Client Name:_____ Date of Birth:_____ Gender: M F

Nick name, or prefer to be called:_____

Legal Guardian's Name:_____ Relationship to Child:_____

Street Address:_____ City/State/Zip:_____

(Please circle or star your preferred phone number)

Home Phone:_____ Messages okay? Y ○ or N ○

Work Phone:_____ Messages okay? Y ○ or N ○

Cell/Other Phone:_____ Messages okay? Y ○ or N ○ Text okay? Y ○ or N ○

Email address:_____ Ok to send email? Y ○ or N ○

Child's Natural Mother's Information: Name:_____

Street Address: Same as above ☐ or: _____ City/State/Zip:_____

Phone:_____

Child's Natural Father's Information: Name:_____

Street Address: Same as above ☐ or: _____ City/State/Zip:_____

Phone:_____

Emergency Contact Name:_____ Relationship:_____

Emergency Contact Phone Numbers:_____

Name(s) of Step-Parent(s) (if applicable):_____

Names and Ages of Siblings (if applicable—Please include step-siblings, half-siblings, etc.):_____

_____

School Child Attends:_____ Grade:_____

Does your child have an Individual Education Plan (IEP)? Y ○ or N ○

Does your family identify with a religious or spiritual community?_____

Please list a few of your child's strengths:_____

_____

Please list a few of your strengths as a family:_____

_____

Please check any current symptoms your child or adolescent is experiencing:

____Depression/Sadness	____Isolation/Withdrawal	____Suicidal Thoughts
____Aggression/Violence	____Homicidal Thoughts	____Self-Harm/Injury, Cutting, Etc.
____Appetite Problems	____Struggles with Social Skills	____Anxiety, Panic, Worry, or Phobia
____Sleep Disturbance/Nightmares	____Difficulty Expressing Feelings	____Obsessions and/or Compulsions
____Bed Wetting or Soiling Issues	____Victim of Abuse	____Low Self-Esteem/Confidence
____Anger/Irritability	____Perpetrator of Abuse	____Problems Thinking/Concentrating
____Relationship Conflicts	____Separation Anxiety	____Pronounced Mood Swings
____Grief/Loss	____Alcohol/Substance Abuse	____Stress/Feeling Overwhelmed
____Chronic Medical Problems	____Issues around Divorce/Separation	____Legal Problems
____Binging/Purging/Anorexia	____Blended Family Issues	____Oppositional Behavior
____Tantrums	____Inattention	____Stealing
____Had Difficult Birth/Pregnancy	____Hyperactive	____Lying/Manipulative Behavior
____Impulse Control Difficulty	____Risk Taking Behavior	____Destruction of Property
____Animal Abuse	____Questioning of Sexual-Orientation	____School Problems or Truancy
____Fire Setting	____Running Away	____Attachment/Bonding Difficulties

Has your child/adolescent experienced any traumatic events? Y○ or N○ If so, please describe:_____

_____

Has your child/adolescent witnessed significantly heated arguments in the home? Y○ or N○

Indicate any current medications related to mental health/behavioral health (e.g., anti-depressants, anti-anxiety, sleep medications, etc.):_____

Name and phone number of prescribing professional:_____

If not on medication, is a referral for a medication evaluation needed? Yes ○ No ○ Maybe ○

Please list any current physical health concerns:_____

Please list past and present tobacco, alcohol, and drug use:_____

Who referred you to see me?_____ (e.g., friend, name of doctor, name of website, etc.)

At times, I write a newsletter with articles and tips that may provide additional help. May I email you my newsletter? (Your confidentiality will be protected, and your information will never be given to a third party.) Y○ or N○

What concern brings you in? What goals do you hope to achieve through counseling? _____

_____

_____

Has your child/adolescent participated in therapy before? If so, what was helpful and/or unhelpful about the experience? If not, what hopes and/or reservations about therapy do you or your child have?_____

_____

_____

How do you feel therapy for your child/adolescent can be most helpful? Do you or your child have thoughts or preferences about how you would like therapy to proceed? _____

_____

Thank you for taking the time to complete this information!