CLIENT INFORMATION F O R M

Please provide the following information and answer the questions below about your child. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Client's Name: _____

(Last) (First) (Middle Initial)

Name of parents/guardians (if under 18 years):

_____

(Last) (First) (Middle Initial)

_____

(Last) (First) (Middle Initial)

Who does your child reside with?

Client's Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Parent's Marital Status:

□ Never Married □ Domestic Partnership □ Married □ Separated

□ Divorced □ Widowed

Is there a legal custody agreement in place for your child?

Please list your child's siblings/age: _____

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

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

Referred by (if any): _____

Has your child previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: _____

Is your child currently taking any prescription medication?
□ Yes
□ No

Please list: _____

_____

Has your child ever been prescribed psychiatric medication?
□ Yes
□ No

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 your child 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 your child 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 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, when did they begin experiencing this? _____

7. Is your child currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe: _____

8. Does your child drink alcohol? □ No □ Yes

9. Does your child engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Is your child currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate that relationship? _____

11. What significant life changes or stressful events has your child experienced recently:

_____

_____

_____

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 you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	_____
Anxiety	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. What do you consider to be some of your child's strengths?

2. What do you consider your child's weaknesses to be?

3. What are your primary concerns about your child?

4. What would you like your child to gain from counseling?

5. Please provide any additional information about your child below-