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Client Information Form:

NAME _____

DATE OF BIRTH: _____ GRADE: _____

SCHOOL: _____

PARENTS' NAMES: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL: _____

PREFERRED METHOD OF CONTACT: _____
IS IT OKAY TO LEAVE MESSAGES ON HOME PHONE, WORK PHONE, CELL PHONE?

Marital Statue: _____

SPOUSE'S NAME:
_____

SPOUSE'S PHONE:
_____

WHOM MAY I CONTACT IN CASE OF AN EMERGENCY?

Name: _____PHONE: _____

IN CASE OF EMERGENCY NOTIFY:
_____

RELATIONSHIP: _____ PHONE NUMBER: _____

COUNSELING INFORMATION:
Please describe the event(s) that occurred which influenced your decision to come to counseling:

What have you already tried to do about your concern?

Has your child ever been to counseling or therapy? _____ yes _____no

What did you find beneficial about counseling? And what did you not find beneficial?

Please mark an X on the line below at a point that reflects your feelings about resolving the concern.

_____1_____2_____3_____4_____5_____
very hopeful somewhat hopeful unsure somewhat hopeless very hopeless

MEDICAL INFORMATION:
Describe any existing medical problems or current physical symptoms:

Please list any major past illnesses, surgeries, and/or hospitalizations:

List all prescribed or non-prescribed medications your child takes on a regular basis:

FAMILY INFORMATION:

Please list the first names, ages, and relationships of the people your child lives with:

Please describe any family history of mental health issues:

Please describe your family's use of alcohol and/or drugs:

Please describe for your child (excellent, good, poor, or frequency of use):

Health _____ Sleep _____

Appetite _____ Energy Level _____

Tobacco Use _____ Alcohol Use _____

Drug Use _____ Caffeine Use _____

Please check any specific issues you have concerns about:

Academics/Grades _____
Peer Relationships _____
Relationship with Family Members _____
Relationships at Work or School _____
Death or Loss of Significant Person _____
Dating/Romantic Relationships _____
Anxiety ____
Use of Social Media ____
Behavior _____
Fears ____
Spiritual Concerns _____
Ethnic/Racial Concerns _____
Self Esteem/ Self Confidence _____
Restless, Racing Thoughts _____
Assertiveness/Shyness _____
Decision-making Abilities _____
Education/Career _____
School Attendance _____
Abuse: physical, sexual, emotional _____
Physical stress (headaches, stomachaches, illness) _____
Perfectionism _____
Difficulty Concentrating _____
Depression _____
Loneliness _____
Food Issues _____
Body Image _____
Relationship with Partner _____
Financial Concerns _____

Have their been issues with:
_____ Marijuana _____Alcohol _____Cocaine
_____Methamphetamines
_____ Heroin _____ Prescription Medicines that are not prescribed
Please describe.

Please comment on any experience with physical/sexual/emotional abuse:

Who is your child's primary support system? (friends, family, church, significant other, etc.)?

Has your child expressed thoughts of physically harming him/herself or someone else recently?

Has your child ever attempted to physically harm him/herself or someone else?

Is there any other information you feel would be helpful?

How would you like for things to be different when we're through meeting?