ATLAS COUNSELING

10176 Corporate Square Dr. | Suite 100-S | St. Louis, MO 63132 | www.atlascounselingstl.com
Phone: 314-991-0100 x 728 (Laura Brackett) or x 740 (Julie Mattingly) | Fax: 314-991-0100

NEW YOUNG CLIENT INFORMATION FORM

The following information should be completed by the client's legal guardian.

Client Information

Client Name (Last, First, MI) | Date of Birth | Age

School | Grade

Please list everyone who lives in the home with the client including their name, age, and relationship to client.

Legal Guardian Information

Name(s) | Relationship to Client

Address | City/State/Zip | Phone Number

Caregiver Information

Please complete the following information if the client is in the physical care of someone other than the legal guardian, such as a foster parent or kinship placement.

Name(s) | Relationship to Client

Address | City/State/Zip | Phone Number

Please list any other caregivers with whom the client spends significant time including name, age, and relationship to client.

History of Care

Please list any medications the client is currently taking (name, dosage, prescriber, reason for medication).

Please list any mental health care the client is currently receiving (name of practitioner, dates of care).

Please list any psychiatric medications the client has taken previously (name, dosage, prescriber, reason for medication).

Please list any mental health care the client has received previously, including inpatient care or hospitalization for psychiatric reasons (name of practitioner, dates of care).

Please list any mental disorders or learning disabilities with which the client has been diagnosed.

Biological Family Information

Biological Mother's Name | Age

Address | City/State/Zip | Phone Number

Employer | Title | Years at Position

Biological Father's Name | Age

Address | City/State/Zip | Phone Number

Employer | Title | Years at Position

Biological Sibling Name(s) and Age(s)

Family Mental Health History

In the section below, please identify if there is a family history of any of the following conditions.

	No	Yes	Relationship to Client
Alcohol/Substance Use			
Anxiety			
Bipolar/Manic-Depression			
Depression			
Domestic Violence			
Obsessive Compulsive Behavior			
Schizophrenia			
Suicide/Suicide Attempts			

Caregiver Observations

Please circle all of the following that you have observed in your child.

Decreased appetite	Increased appetite	Throwing up after eating	Refusing to eat
Nightmares	Difficulty falling asleep	Difficulty staying asleep	Sleeping during the day
Headaches	Stomach aches	Aches and pains	Fatigue
Picking at skin/nails	Pulling out hair/lashes	Chewing lips/fingers	Cutting/burning self

Has the client ever reported wanting to hurt or kill him/herself? □ No □ Yes

Has the client ever reported wanting to hurt or kill someone else? □ No □ Yes

Has the client ever attempted to hurt or kill him/herself? □ No □ Yes

Has the client ever attempted to hurt or kill someone else? □ No □ Yes

Please indicate, to the best of your knowledge, if the client has used any of the following substances.

	Never Used	Currently Using	Previously Used	Amount (if currently using)
Alcohol				
Marijuana				
Cocaine/crack				
Heroine/Narcotics				
Amphetamines				
Depressants				
PCP				
LSD				
Inhalants				
Tobacco/Nicotine				
Caffeine				
Other				

Client Health History

How would you rate the client's current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any significant physical illnesses, injuries, or surgeries that the client has experienced or is currently experiencing.

_____

_____

_____

Additional Information

What significant life changes or stressful events has the client experienced recently?

What do you consider to be some of the client's strengths?

What do you consider to be some of the client's challenges?

What would you like the client to accomplish out of his/her time in therapy?

Caregiver Signature Date

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NEW YOUNG CLIENT INFORMATION FORM

The following information should be completed by the client, as they are able.

Self-Identity

_____

Please let us know how you identify your gender, and if you have specific pronouns you prefer to be addressed with.

_____

Please let us know how you identify your sexuality.

_____

Please let us know how you identify your race or ethnicity.

_____

Please let us know if you identify strongly with a specific culture.

_____

Please let us know if you have any spiritual or religious beliefs that are important to you.

Are you currently in a romantic relationship(s)? □ No □ Yes

If yes, how long have you been in the relationship(s)? _____

Overall, how would you rate your relationship(s)? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

General Health and Welfare

How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please let us know of any specific sleep concerns you are currently experiencing.

_____

_____

How would you rate your current eating habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please let us know of any specific appetite or eating pattern concerns you are currently experiencing.

_____

_____

How many times per week do you generally exercise, and in what types of exercise do you participate?

_____

_____

Are you currently experiencing any chronic pain? If yes, please describe below. □ No □ Yes

_____

_____

Are you currently experiencing overwhelming sadness, grief, or depression? □ No □ Yes

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias? □ No □ Yes

If yes, for approximately how long? _____

Please indicate if you have used any of the following substances.

	Never Used	Currently Using	Previously Used	Amount (if currently using)
Alcohol				
Marijuana				
Cocaine/crack				
Heroine/Narcotics				
Amphetamines				
Depressants				
PCP				
LSD				
Inhalants				

	Never Used	Currently Using	Previously Used	Amount (if currently using)
Tobacco/Nicotine				
Caffeine				
Other				

Additional Information

What significant life changes or stressful events have you experienced recently?

Do you enjoy school? Is there anything stressful about school?

What do you consider to be some of your strengths?

What do you consider to be some of your challenges?

What would you like to accomplish out of your time in therapy?

_____

_____

_____

_____

Client Signature Date