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CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _____

Your child's name: _____
Last First Middle Initial

Parent or Guardian's name: _____
Last First Middle Initial

Child's Date of birth: _____ Gender: _____

Parent or Guardian's Social Security #: _____

Home street address: _____

City: _____ State: _____Zip:_____

Parent or Guardian's Name of Employer: _____

Address of Employer: _____

City: _____ State: _____Zip:_____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Calls will be discreet, but please indicate any restrictions: _____

Referred by: _____

May I have your permission to thank this person for the referral? Yes No

If referred by another clinician, would you like for us to communicate with one another? Yes No

Person(s) to notify in case of any emergency:

_____
Name Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so:

(Your Signature): _____

Please briefly describe your child's presenting concern(s): _____

_____

_____

What are your/your child's goals for therapy? _____

_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing.

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses your child has had:

_____

_____

Current Medications:

Medication	Dosage	Purpose	Prescribing Doctor

Previous medical hospitalizations (Approximate dates and reasons): _____

_____

Previous psychiatric hospitalizations (Approximate dates and reasons): _____

_____

Has your child ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO

(Please list approximate dates and reasons): _____

_____

Sexual & Gender Identity: _____

FAMILY:

How would you describe your child's relationship with his/her mother? _____

How would you describe your child's relationship with her/his father? _____

Are the child's parents still married? _____ If they divorced, how old was the child when they separated or divorced, and how did this impact him/her? _____

_____

Were there any other primary care givers who your child had a significant relationship with? If so, please describe how this person may have impacted her/his life: _____

_____

How many sisters does your child have? _____ Ages? _____

How many brothers does your child have? _____ Ages? _____

How would you describe his/her relationships with siblings? _____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Child's Current Relationship Satisfaction with friends: POOR 1 2 3 4 5 6 7 EXCELLENT

How would you describe your child's relationship with peers? _____

_____

Please briefly describe any history of abuse, neglect and/or trauma: _____

_____

Please briefly describe your child's self-care and coping skills: _____

What are your child's diet, weight, and exercise/activity patterns? _____

_____

Please briefly describe your child's school performance and experience: _____

_____

What are your child's hobbies, talents, and strengths? _____

_____

PLEASE CHECK ALL THAT APPLY & CIRCLE THE MAIN PROBLEM:

Difficulty with…	Now	Past	Difficulty with…	Now	Past	Difficulty with…	Now	Past
Anxiety			Tantrums			Nausea		
Depression			Parents divorced			Stomach aches		
Mood changes			Seizures			Fainting		
Anger or temper			Cries easily			Dizziness		
Panic			Problems with friends			Diarrhea		
Fears			Problems in school			Shortness of breath		
Irritability			Fear of strangers			Chest pain		
Concentration			Fighting with siblings			Lump in throat		
Headaches			Issues re: divorce			Sweating		
Loss of memory			Sexually acting out			Heart problems		
Excessive worry			History of child abuse			Muscle tension		
Wetting the bed			History of sexual abuse			Bruises easily		
Trusting others			Domestic violence			Allergies		
Communicating			Thoughts of harming others			Makes careless mistakes		
Separation anxiety			Hurting self			Fidget frequently		
Alcohol/drugs			Thoughts of suicide			Impulsive		
Drinks caffeine			Sleeping too much			Waiting turn		
Frequent vomiting			Sleeping too little			Completing tasks		
Eating problems			Getting to sleep			Paying attention		
Weight gain			Waking too early			Easily distracted		
Weight loss			Nightmares			Hyperactivity		
Head injury			Sleeping alone			Chills or hot flashes		
Family History of:								
Drug/alcohol problems			Physical abuse			Depression		
Legal trouble			Sexual abuse			Anxiety		
Domestic violence			Hyperactivity			Psychiatric hospitalization		
Suicide			Learning disabilities			"nervous breakdown"		

Any additional information you would like to include: _____

_____

_____

_____

_____

_____

_____