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Child or Adolescent Client Information Form
(Please print)

Please note: This form is completely confidential. Your first session is considered to be an Assessment Session to decide whether the clinician is an appropriate fit for you, the client, and to establish a treatment plan.

Today's Date: ______________________ Child's Name: ____

Parent or Legal Guardian's Name: __________________________Relationship to Child: _________________

Home Address: ____________________________City: ___________________ State: ____ Zip: ___________

Home Phone #: ___________________ Work Phone #: _____________________

Mother's/Guardian Cell #: ____________________ Father's/Guardian Cell #________________________

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

Child's Date of Birth:__________ Gender:______ Child Cell Phone (not Required):_____________________

Parent Email address: __________________________________

Person(s) to notify in case of any emergency: : ______________________________ _________________
Name Phone

I will only contact the person(s) noted above if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Parent/Guardian Signature): _____________________

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

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

____

____

What are your or your child's goals for treatment: ____

____

____

MEDICAL HISTORY:

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

____

Current Medications:

Name of Medication	Dosage	Purpose	Name of 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? (If yes, please list name, phone number, reason, and approximate date): ______________________________

____

____

Who is your child's physician (name and phone #) and what was the date last seen? _________________

____

Were there any other pertinent care givers who have had a significant relationship with your child? If so, please describe how these people may have impacted your child's life: _______________________

____

____

SOCIAL SUPPORT, SELF-CARE, & EDUCATION:

POOR EXCELLENT

Child's current level of satisfaction with friends and social support: 1 2 3 4 5 6 7

How would you describe your child's relationships with his/her peers? _____________________________

____

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

____

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

____

EDUCATIONAL HISTORY (Note: We will not contact the school without a separate, signed release of information form)

Name of school____________________________ Name of school counselor/principal____________________

School Phone Number ________________________ Previous school(s) attended _______________________

Has the child ever repeated a grade? ☐ Yes ☐ No If so, when? ___________________________________

Describe any learning difficulties ____

Has there been any discipline or behavior problems at school? ☐ Yes ☐ No

If so, please describe: ____

____

LEGAL BACKGROUND

Has your child ever been in any legal trouble? ☐ Yes ☐ No

If so, please describe____

CUSTODY INFORMATION Who has legal custody of the child/teen? (List names and phone numbers of all custodial parties.)

____

____

Who does the child reside with? ___________________________

Is custody of the child/teen being disputed? ☐ Yes ☐ No

If so, please describe: ____

____

In the event of a divorce or separation agreement, please provide a copy of your custodial agreement.

OVER

PLEASE CHECK ALL THAT APPLY & *CIRCLE* THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety →			People in General →			Nausea →		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/Partnership			Diarrhea		
Panic			Friend(s)			Shortness of Breath		
Fears			School/Work			Chest Pain		
Irritability			Finances			Sweating		
Concentration			Legal Problems			Heart Palpitations		
Headaches			Sexual Concerns			Muscle Tension		
Loss of Memory			History of Child Abuse			Allergies		
Excessive Worry			History of Sexual Abuse			Fidget Frequently		
Feeling Manic			Domestic Violence			Hyperactivity		
Trusting Others			Impulsiveness			Chills or Hot Flashes		
Communicating with Others			Thoughts of Hurting Others			List any additional difficulties below:		
Drugs			Hurting Self					
Alcohol			Thoughts of Suicide					
Addictive Behaviors			Attempted Suicide					
Frequent Vomiting			Sleeping Concerns					
Eating Problems			Nightmares					
Severe Weight Gain			Hearing Voices					
Severe Weight Loss			Head Injury					
Blackouts			Dizziness					

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems		Physical Abuse		Depression	
Legal Trouble		Sexual Abuse		Anxiety	
Domestic Violence		Hyperactivity		Psychiatric Hospitalization	
Suicide		Learning Disabilities		Attempted Suicide	