

Minor Client Information

Date of Initial Visit _____ Social Security # _____ - _____ - _____

Name _____ Date of Birth _____
First Middle Last

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ - _____

Name of School Attending _____ Grade _____ Phone (____) _____ - _____

Please check custodial parent:

___ Mother's name _____ Date of Birth _____ Phone: (____) _____ - _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

___ Father's name _____ Date of Birth _____ Phone: (____) _____ - _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

List All Who Are Living in Household:

<u>Name</u>	<u>Relationship</u>	<u>Age</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Recent deaths of family/friends (Relation/dates) _____

List current illness(es) or symptoms _____

List any major surgeries, serious crises, losses, or handicaps (with dates) _____

Last Medical Exam _____ Reason _____

Name and Address of Physician _____

Current Medications Child/Adolescent is taking _____

Has your child/adolescent ever received psychotherapy, counseling, or other treatment for personal or family problems?

____ Yes ____ No Dates _____

Name of Professional (Dr., agency, pastor, etc.) _____

Have you or any member of your family ever received or considered seeking help for drug or alcohol dependency?

____ Yes ____ No Dates _____ Name of Professional/Agency _____

Substances Used _____

Who referred you to my practice? _____

Person Responsible for Payment _____

Type of Therapy Desired: ____ Individual ____ Family

Racial/Ethnic Identity: __ African-American __ Asian __ Caucasian __ Hispanic __ Native American __ Other _____

Religious Preference _____ Local Congregation _____

Emergency Contact Person _____ Phone: (____) _____ - _____

IMPORTANT QUESTIONS FOR YOU AND YOUR CHILD/ADOLESCENT'S THERAPIST

Please describe your reason(s) for seeking help _____

What would you like to have happen for you and/or your child/adolescent as a result of therapy? _____