Minor Client Application

Today's Date
Name Date of Birth
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:

FAMILY INFORMATION

List All Who Are Living in Household:

Name	**Relationship**	**Age**

MEDICAL INFORMATION

How would you describe your child's health?
Has there been any change in his or her weight this past year? ☐ Yes ☐ No If yes, please explain:

Has there been any change in his or her sleep patterns this past year? ☐ Yes ☐ No If yes, please explain:

Physician Name Physician Address:
Physician Phone: ( )
When was his or her last medical exam?
Current medications s/he is taking & for what purposes

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

Does alcohol or any form of drug or medication contribute to your present concerns? ☐ Yes ☐ No

COUNSELING BACKGROUND

Has your child/adolescent received psychotherapy, counseling, or other treatment for personal or family problems?
☐ Yes ☐ No Dates By whom?

For what purpose?

Who referred you to my practice?

Person Responsible for Payment

Type of Therapy Desired: ☐ Individual ☐ Family ☐ Group

Religious Preference Local Congregation

Please list your child's strengths, hobbies, sporting activities or interests:

Please describe your reason(s) for seeking assistance now

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

I have read the disclosure statement and understand that I have the opportunity to ask any questions.

Signature Date
Counselor Date