Minor Client Information

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

Name _____ Date of Birth _____
First Middle Last

Address _____ City_____ State_____ Zip _____

Home Phone (_____) _____-_____ Email address: _____

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:

Name	Relationship	Age

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

List current illness(es) or symptoms _____

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

(Continued on Reverse Side)

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 ____ Group

Racial/Ethnic Identity: __African-American __Asian __Caucasian __Hispanic __Native American __Other_____

Religious Preference _____ Local Congregation _____

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

Type of Therapy desired: ___ Individual ___ Family ___ Group

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

_____

_____

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?_____

_____

_____

_____

_____