Client Information Form (Child/Adolescent)

Today's date: ___________________

A. Identification

Your name: ____________________________ Date of birth: ____________ Age: _______
Nicknames or aliases: _______________________ Social Security# __________________
Home street address: ____ Apt.: ____
City: ________________________________ State: ___________ Zip: ______________
Home/evening phone: ____________________ e-mail: _____________________________

Name of parent/guardian: __________________________ Phone:____________________

May we leave a message? □ Yes □ No
May we send you a text? □ Yes □ No
May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

B. Chief Concern: Please describe the main difficulty that brought you to see me:

____
____
____

C. Emergency Information

If some kind of emergency arises and I cannot reach you directly or we need to reach someone close to you, whom should we call?

Name: _______________________Phone:_________________ Relationship:___________
Address: ____

D. Your Education

Dates	School	Special Classes?	Adjustment to School

E. Your Medical Care: From whom or where do you get your medical care?

Clinic/Doctor’s name: ___________________________________ Phone: __________________

Address: ____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? □ No □ Yes

F. Medical History

Starting with your childhood and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had.

Age	Illness/Diagnosis	Treatment Received	Treated by	Result

List all medications, drugs, or other substances you take – prescribed or over-the-counter.

Medication/Drug	Dose (how much/how often)	Take for	Prescribed and supervised by

G. Psychiatric History

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before? □ No □ Yes If yes, please indicate:

Date	Provider	For what?	Results

Have you ever taken medications for psychiatric or emotional problems? □ No □ Yes
If yes, please indicate:

Date	Provider	Medication	For what?	Results

Do you have any allergies? ____

H. Alcohol and Substance Use

How much beer, wine, or hard liquor do you consume each week, on average? ________

How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

Please list: ____

I. Family-of-Origin History

Relative	Name	Current Age (or age at death)	Illnesses (or cause of death, if deceased)
Father			
Mother			
Brothers			
Sisters			
Stepparents			

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	

Eating Disorders yes/no
Schizophrenia yes/no
Suicide Attempts yes/no
Other ______________________ yes/no

J. Marital/Relationship History
Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? __________________

On a scale of 1-10, how would you rate your relationship? __________

K. Please list any children and ages: _________________________________

L. Legal History

1. Are you presently suing anyone or thinking of suing anyone? No Yes
   If yes, please explain: ____
2. Is your reason for coming to see me related to an accident or injury? No Yes
   If yes, please explain: ____
3. Are you required by a court, the police, or a probation/parole officer to have this appointment? No Yes If yes, please explain: ___________________________
   ____

M. Other

Is there anything else that is important for me as your therapist to know about, and that you have not written on any of these forms? If yes, please tell me about it or write it here: _____
____
____
____
____
____
____
____
____

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.