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CLIENT INFORMATION FORM (MINOR) Today's Date ________________

IDENTIFICATION

Guardian Name: ____ Date of Birth: ________________

Name of minor in treatment: _________________________________ Date of birth _____________

Relationship to you: ___________________________ Guardian: ___________________________

Home address: _____________________________________ parent email: ______________________

_____________________________________ minor email: _______________________

Preferred contact number: _____________________ alternate number: _______________________

Any restrictions on messages or other types of contact: ______________________________________

____

Others attending and relationship: ____

____

INSURANCE

Insurance provider: ____________________________ Policy # ______________________

Insured's Name: ________________________________ Group # ______________________

Relationship to Insured: _________________________ Co-pay amt: ________________

EMPLOYMENT

Current Employer ______________________________ Phone: _______________ Ok to call? Y/N

Address: ____

Referral: How were you referred to me? ____

Main concerns for your visit: ____

____

Are you having or have you had previous psychotherapy? □No □Yes

Previous therapist's name____________________________ Last visit: _______________

Concerning: ____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? □Yes □No

If Yes, please list: ____

PRESENTING PROBLEMS of MINOR

1. How is your physical health at present? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc): ______________________________

3. Are you having any problems with your sleep habits? □ No □ Yes

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams

□ Other ______________________________

4. Are you having any difficulty with appetite or eating habits? □ No □ Yes

If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting

Have you experienced significant weight change in the last 2 months? □ No □ Yes

5. Do you regularly use alcohol? □ No □ Yes How often/amount: ____________

6. Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

7. Are you currently in a romantic relationship? □ No □ Yes For how long: ____________

On a scale of 1-10, how would you rate the quality of your current relationship? ______

8. In the last year, have you experienced any significant life changes or stressors: __________

____

Have you ever experienced:

- ☐ Extreme depressed mood
- ☐ Wild Mood Swings
- ☐ Rapid Speech
- ☐ Extreme Anxiety
- ☐ Panic Attacks
- ☐ Phobias
- ☐ Sleep Disturbances
- ☐ Hallucinations
- ☐ Unexplained losses of time
- ☐ Unexplained memory lapses
- ☐ Alcohol/Substance Abuse
- ☐ Frequent Body Complaints
- ☐ Eating Disorder
- ☐ Body Image Problems
- ☐ Repetitive Thoughts (e.g., Obsessions)
- ☐ Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)
- ☐ Homicidal Thoughts
- ☐ Suicide Attempt

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? □ No □ Yes

If yes, what is your faith? ______________________________

If no, do you consider yourself to be spiritual? □ No □ Yes

☐ I have been given the information on confidentiality and HIPAA.

______________________________ ____________

Signature Date