MINOR CLIENT:

Name: _____ **Sex:** M F **AGE:** _____ **DOB:** _____/_____/_____

School Status: ___Home School ___Public/Private School (Name)_____

**Parent/Guardians in the child's home: _____Mother ____Father ____Guardian ____ other _____

Custody Arrangements (if apply) _____

Parent/Guardian Information (please fill out all that is different from child)

MOTHER'S NAME: _____AGE: _____DOB: _____/_____/_____

Address: (if different from above) _____

City/Sate/Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Employment: _____Work Phone: (_____)_____

Email: _____Driver's License: STATE: _____#: _____

Status: ____Student ____ Single ____Married ____Separated ____Divorced ____Widowed ____RE-married

Stepparent Name: _____

_____

List all of the other **children in the home** and their ages:

FATHER'S NAME: _____AGE: _____DOB: _____/_____/_____

Address: (if different from above) _____

City/Sate/Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Employment: _____Work Phone: (_____)_____

Email: _____Driver's License: STATE: _____#: _____

Status: ____Student ____ Single ____Married ____Separated ____Divorced ____Widowed ____RE-married

Stepparent Name: _____

_____

List all of the other **children in the home** and their ages:

Medications **Name: _____**

Is your child currently taking any **prescription medications**? __ No ___Yes, if so please list:

Medications:

1) _____ 2) _____

Has your child ever been prescribed *psychiatric* medications in the past? ___No ___Yes _____

General Physical Health of your child**:** Height _____ Weight _____

Pediatrician: _____ Date of last visit: _____

How would you rate your child's ***current physical health***?

___Poor ___ Unsatisfactory ___ Satisfactory ___ Good ___ Very Good

How would you rate your child's ***current sleeping habits***?

___Poor ___ Unsatisfactory ___ Satisfactory ___ Good ___ Very Good

How would you rate your child's **appetite?**

___Poor ___ Unsatisfactory ___ Satisfactory ___ Good ___ Very Good

Is your child involved in any ***after school sports or activities*** ____No ___ Yes

If so, what type and how often? _____

On average, how many ***hours per day of screen time*** is your child exposed to?

(i.e. TV, computer, I pad, IPhone, Gaming)? _____

Does your child have an understanding of **spirituality**? Is he/she affiliated with a **religion**?

_____

Previous Behavioral/Mental Health History of our child:

Have you or your child previously received any type of mental health services (i.e. evaluation by psychologist, psychotherapy, counseling, or psychiatric services)? __ No__ Yes, if so please provide the previous therapist/practitioner: _____

Is there anyone in your child's family who has a history of (check all that apply):

___Alcohol/Substance Abuse ___ ADHD ___Anxiety ___Depression

___Domestic Violence ___ Dyslexia ___Eating Disorders ___Obesity

___Obsessive/Compulsive Behavior ___Schizophrenia ___Suicide Attempts

Event History: Name: _____

(Describe any major changes that have occurred in the life of your child, you, or your family)

In the last year: _____

In the past five years: _____

In your lifetime: _____

Today's concern: (What is your reason for seeking counseling for your child today?):

(HOME): _____

(SCHOOL): _____

Personal (Child)

1. What do you consider to be some of **your child's strengths?**

_____

2. What do you consider to be some of **your child's weaknesses?**

_____

3. What would you like to see accomplished from your child's time in therapy?

_____

Personal (Parents)

1. What do you consider to be some of **your strengths as a parent?**

_____

2. What do you consider some of **your weaknesses as a parent?**

_____

Referred by: _____
