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# New Minor Client Information

**PERSONAL INFORMATION** Today's Date: ________________

First Name: ______________________ Nickname: _______________ Last Name: __________________________

Primary Address: ____________________________________ City: __________________ State: ____ Zip:__________

Age: _______ Date of Birth: ____/____/____ Gender: _______________

Cell Phone: (_____) ___________________ May we leave a voicemail message: ❑ Yes ❑ No

Home Phone: (_____) ___________________ May we leave a voicemail message: ❑ Yes ❑ No

Email: _______________________________________ May we email you: ❑ Yes ❑ No

Preferred Email for reminder of scheduled appointments (if different): _______________________________

Note: Phone and/or email correspondence is not considered to be a confidential medium of communication for clinical discussions.

**EMERGENCY CONTACT(S)**

Name: _________________________ Relationship: _______________ Phone: (_____) ________________

Name: _________________________ Relationship: _______________ Phone: (_____) ________________

**Current School:** __________________________________________ **Grade:** ______________ 504/IEP: ❑ Yes ❑ No

**FAMILY**

**Mother** Name: ______________________________ Address: ________________________________________

Cell Phone: ___________________ Home Phone: ___________________ Work Phone: ___________________

Email: _______________________________________

**Father** Name: ______________________________ Address: ________________________________________

Cell Phone: ___________________ Home Phone: ___________________ Work Phone: ___________________

Email: _______________________________________

Parents are: ❑ Married ❑ Separated ❑ Divorced If **separated or divorced**, please describe custody arrangements and schedule: __________________________________________________________________

______________________________________________________________________________________

**PRIMARY HOME: Please list all members living in the home.**

| **Name** | **Age** | **Relation (mom, brother, etc.)** | **Describe your relationship with this person.** |
|---|---|---|---|
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**SECONDARY HOME, if parents are separated or divorced: Please list all members living in the home.**

| Name | Age | Relation (mom, aunt, etc) | Describe your relationship with this person. |
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**CURRENT MENTAL HEALTH CONCERNS**

Reason for Visit- Current concerns bringing you to therapy? ______________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

What are your goals from therapy? ______________________________________________________

______________________________________________________________________________

______________________________________________________________________________

How does your child feel about coming to therapy? _______________________________________

______________________________________________________________________________

Describe your parenting style: _________________________________________________________

______________________________________________________________________________

**Current Home Concerns**

| Check: | Please describe: |
|---|---|
| ❑ Emotional | |
| ❑ Social/Family | |
| ❑ Behavioral | |
| ❑ Academic | |

**Current School Concerns**

| Check: | Please describe: |
|---|---|
| ❑ Emotional | |
| ❑ Social | |
| ❑ Behavioral | |
| ❑ Academic | |

**Please check all items below that apply to your current concerns about your child.**

| X | Concern | Comments | X | Concern | Comments |
|---|---|---|---|---|---|
| | Abortion | | | Indecisive | |
| | Academic concerns | | | Infertility | |
| | Addiction concerns | | | Internet/video game addiction | |
| | ADHD/ADD | | | Intimate relationship concerns | |
| | Adjustment/life changes | | | Irritable | |
| | Aggressive behavior | | | Isolation/social withdrawal | |
| | Aging parents | | | Learning concerns | |
| | Alcohol | | | Legal concerns | |
| | Anger/frustration management | | | Low energy/fatigue | |
| | Anxiety, fear, nervousness | | | Loneliness | |
| | Appetite changes | | | Lying | |
| | Argumentative | | | Manic behavior | |
| | Blended family issues | | | Marital affairs | |
| | Burnout | | | Medical or health concerns | |
| | Career/job | | | Memory problems | |
| | Children/parenting | | | Mood swings | |
| | Chronic pain | | | Motivation | |
| | Codependency | | | Nail-biting | |
| | Communication | | | Nightmares/night terrors | |
| | Compulsive behavior | | | Obsessive thoughts | |
| | Concentration difficulties | | | Overspending | |
| | Crying | | | Paranoia | |
| | Cutting or self-injury | | | Phobias | |
| | Delusion/hallucinations | | | Physical abuse or assault (past or present) | |
| | Depression/sadness | | | Picking | |
| | Difficulty trusting others | | | Poor boundaries | |
| | Distraction | | | Pornography | |
| | Divorce/separation | | | Procrastination | |
| | Domestic violence concerns | | | Relationship stress/conflict | |
| | Drugs | | | Running away | |
| | Eating concerns (binge, purge, obesity) | | | Self-control | |
| | Eating Disorders (anorexia, bulimia, binging) | | | Self-esteem | |
| | Emotional or psychological abuse (past or present) | | | Self-harming thoughts/actions | |
| | Family concerns | | | Separation anxiety | |
| | Fears of abandonment/rejection | | | Separation/marital concerns | |
| | Feeling that you/things around you are not real | | | Sexual function | |
| | Fidgeting | | | Sexual abuse or assault (past or present) | |
| | Financial concerns | | | Sexuality concerns | |
| | Fire setting | | | School/Work absenteeism/avoidance | |
| | Flashbacks (not drug related) | | | Shyness | |
| | Focusing difficulties | | | Single parent | |
| | Forgetfulness | | | Sleep difficulties/changes | |
| | Gambling | | | Social concerns/social skills struggles | |
| | Grief/loss | | | Spiritual or religious concerns | |
| | Guilt/shame | | | Stealing | |
| | Harassment | | | Stress or tension | |
| | Harming Animals | | | Suicidal thoughts/actions | |
| | Hoarding | | | Thoughts racing/can’t hold on to an idea | |
| | Homicidal thoughts | | | Tobacco use | |
| | Hopelessness | | | Transition difficulties | |
| | Hormone struggles/PMS | | | Trouble making decisions | |
| | Hygiene/self-care | | | Unemployment | |
| | Hyperactive | | | Violence | |
| | Impulse control | | | Weight loss/gain +/- _____lbs | |
| | Inappropriate sexual behavior | | | | |

| Current Prescriptions | Dosage | Frequency | Prescribed for | Using since | Prescribed by |
|---|---|---|---|---|---|
| | | | | / / | |
| | | | | / / | |
| | | | | / / | |
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| OTC Medications and Supplements | Reason | Frequency |
|---|---|---|
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| | | |

**PAST MENTAL HEALTH**

Past mental health and substance issues:____________________________________________________________

____________________________________________________________________________________

Any previous therapy? ❑ Yes ❑ No If yes, with whom? Dates? ___ ________________________________________

Reason? ____________________________________________________________________________

Helpful? ❑ Yes ❑ No ❑ Some Comments: ________________________________________________________

Reason for discontinuing therapy: _______________________________________________________________

Previous diagnoses? ❑ Yes ❑ No If yes, please explain: what diagnosis, age, name of doctor. _________________

____________________________________________________________________________________

____________________________________________________________________________________

Past Psychological/learning evaluation or testing? ❑ Yes ❑ No If yes, name of clinician and date: ______________

____________________________________________________________________________________

Past suicidal thoughts or attempts? ❑ Yes ❑ No If yes, when: _____________________________________________

Past homicidal thoughts or attempts? ❑ Yes ❑ No If yes, when: ___________________________________________

Past traumatic experience(s)? ❑ Yes ❑ No If yes, please list when and briefly describe: ________________________

____________________________________________________________________________________

Previous in-patient psychiatric hospitalization? ❑ Yes ❑ No If yes, number of hospitalizations: _______________

Please list date of and reason for hospitalization(s). ________________________________________________

____________________________________________________________________________________

Family History of Psychiatric/Emotional/Behavioral/Substance Abuse problems: ______________________________

____________________________________________________________________________________

____________________________________________________________________________________

List any significant mental health, behavioral, or substance abuse problems that your child has previously experienced:

____________________________________________________________________________________

____________________________________________________________________________________

| **Drug Use** | None | Past | Current | | None | Past | Current | |
|---|---|---|---|---|---|---|---|---|
| Alcohol | ❑ | ❑ | ❑ | Cocaine | ❑ | ❑ | ❑ | |
| Marijuana | ❑ | ❑ | ❑ | Heroin | ❑ | ❑ | ❑ | |
| Stimulants | ❑ | ❑ | ❑ | Steroids | ❑ | ❑ | ❑ | |
| Hallucinogens | ❑ | ❑ | ❑ | Other | ❑ | ❑ | ❑ | ___________________ |

Drug of choice: _______________________________ Quit on: _______________________

Caffeine: ❑ No ❑ Yes Amount/Day: _____________________ Source: _____________________

**SCHOOL HISTORY**

| Grade | School | Concerns | Comments |
|---|---|---|---|
| PreK | | ❑ Emotional ❑ Social<br>❑ Behavior ❑ Academic | |
| K | | ❑ Emotional ❑ Social<br>❑ Behavior ❑ Academic | |
| 1st | | ❑ Emotional ❑ Social<br>❑ Behavior ❑ Academic | |
| 2nd | | ❑ Emotional ❑ Social<br>❑ Behavior ❑ Academic | |
| 3rd | | ❑ Emotional ❑ Social<br>❑ Behavior ❑ Academic | |
| 4th | | ❑ Emotional ❑ Social<br>❑ Behavior ❑ Academic | |
| 5th | | ❑ Emotional ❑ Social<br>❑ Behavior ❑ Academic | |
| 6th | | ❑ Emotional ❑ Social<br>❑ Behavior ❑ Academic | |
| 7th | | ❑ Emotional ❑ Social<br>❑ Behavior ❑ Academic | |
| 8th | | ❑ Emotional ❑ Social<br>❑ Behavior ❑ Academic | |
| 9th | | ❑ Emotional ❑ Social<br>❑ Behavior ❑ Academic | |
| 10th | | ❑ Emotional ❑ Social<br>❑ Behavior ❑ Academic | |
| 11th | | ❑ Emotional ❑ Social<br>❑ Behavior ❑ Academic | |
| 12th | | ❑ Emotional ❑ Social<br>❑ Behavior ❑ Academic | |

**MEDICAL HISTORY**

Primary Physician: ____________________________ Phone: _________________ Date of Last Exam: _____________

Psychiatrist: ____________________________________ Phone: __________________ Date of Last Session: __________

Height: ___________ Weight: ___________ Recent Weight Gain/Loss: _________________

Exercise: ❑ No ❑ Daily ❑ Weekly: _____times/week

Does your child have any physical disabilities/limitations? ❑ Yes ❑ No If yes, please explain: _______________________

_____________________________________________________________________________________________________

**Prior Hospitalizations/Surgeries/Injuries**

| Year | Hospitalizations/Surgeries/Injuries | Complications or Other Comments |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

List any significant medical problems that your child has previously experienced or is currently experiencing:

______________________________________________________________________________

______________________________________________________________________________

**CHILDHOOD DEVELOPMENT HISTORY**

Born full term? ❑ Yes ❑ No If no, how many weeks? __________ Complications? ___________________________

Milestones (i.e. sitting, walking, talking) ❑ On time ❑ Average ❑ Late Comments: __________________________

Any current or past involvement with child protective services? _________________________________________

Spiritual/Religious? ❑ Yes ❑ No If yes, briefly describe: _____________________________________________

Strengths, Hobbies & Interests: ___________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Community Involvement (sports, clubs, etc.): ______________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Please describe your child's support system. Who are those closest to them? (family, friends, etc.)

______________________________________________________________________________

______________________________________________________________________________

Any other important information you would like to share: ____________________________________________

______________________________________________________________________________

**By signing below, I certify all information is true and correct to the best of my knowledge.**

_______________________________________________________

Child's Name (Please Print)

_______________________________________________________ ______________________________

Parent or guardian signature Date