

MINOR CLIENT INFORMATION FORM

Today's Date _____

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: _____

Previous diagnosis: _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

Yes No Past If Yes, please list: _____

Any other medications: _____

PRESENTING PROBLEMS

1. How is your physical health at present? Rate **1**(poor) – **5** (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 Past How often/amount: _____
 Recreational drugs? No Yes Past How often/type/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: check and indicate time frame and details

Past / Current

- 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 _____
- Abuse _____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? No Yes What is your faith? _____
 How often do you attend now? _____ Did you attend growing up? _____

I have been given the information on confidentiality and HIPAA.

 Signature

 Date