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## Client Background Information

Please answer all of the information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance if needed.

Child's Name: _____ Today's Date: _____

Parent's Name: _____ Will attend sessions with child? ☐Yes ☐No

Mailing Address: _____
City State Zip

Email Address: _____ Parent's Cell Phone: _____
(May leave message? ☐Yes ☐No

Parent's Work Phone: _____ Other Phone: _____
(May leave message? ☐Yes ☐No) (May leave message? ☐Yes ☐No)

Date of Birth: ___/___/_____ Age: _____ Grade: _____ Father's Age: _____ Mother's Age: _____

Parent's Current Marital Status: ☐Never Married ☐Married ☐Separated ☐Divorced ☐Widowed

Parent's Highest Education Completed: ☐HS diploma ☐GED ☐Associate's ☐Bachelor's ☐Master's ☐Doctorate

Mother's Employer: _____ Occupation: _____

Father's Employer: _____ Occupation: _____

Church: _____ Is your Christian faith an important resource? ☐Yes ☐No

Has your child ever seen a mental health professional (psychiatrist, psychologist, or a counselor)?

☐Yes ☐No

If yes: Where: _____ Dates of Service: _____
(Previous Mental Health Professional/Agency) (beginning - ending)

Has your child ever been hospitalized for mental health concerns? ☐Yes ☐No

If yes: Where: _____ When: _____

## General Information

List your child's current family by household (excluding child):

| Name | Age | Gender | Relationship to child (include step, half, etc.) |
|---|---|---|---|
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Currently involved in a custody dispute: ☐No ☐Yes

If yes, please explain:_____

_____

## Client's Health

Pediatrician/Primary Care Physician Name:_____

Physical Disability: ☐Yes ☐No (If yes, please explain.)_____

Chronic Illness: ☐Yes ☐No (If yes, please explain.)_____

Terminal Illness: ☐Yes ☐No (If yes, please explain.)_____

What medication is your child currently taking?

| Medication | Dosage | Taken for what reason? |
|---|---|---|
| | | |
| | | |
| | | |

## Family History/Experiences

Current Family Stressors: (Check all that apply.)

☐Chronic illness of family member (relationship)_____ ☐Domestic Violence

☐Death of significant person (relationship)_____

☐Family member absent (explain)_____

☐Family member disability/major accident/illness (explain)_____

☐Family member emotional problems (explain)_____

☐Financial Problems ☐Moved a lot ☐Frequent Arguing ☐Divorce

Other_____

History of emotional/behavioral problems: ☐Yes ☐No

(If yes, please explain.) _____

History of alcohol/drug/substance abuse: ☐Yes ☐No

(If yes, please explain.) _____

History of family violence: ☐Yes ☐No

(If yes, please explain.) _____

History of criminal activity: ☐Yes ☐No

(If yes, please explain.)_____

## Current Concerns

Please mark the following items that apply.
(Use initials of child's name and/or family members to differentiate current concerns.)

_____ Abuse (physical, emotional, sexual)
_____ Adjustment to life changes (moving, getting married or divorced, aging, etc.)
_____ Drug or alcohol use (both legal and illegal drugs)
_____ Eating problems (purging, bingeing, overeating, hoarding, severely restricting diet)
_____ Family or Stepfamily relationship problems
_____ Feeling angry or irritable
_____ Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc.)
_____ Feeling sadness or depression NOT related to grief
_____ Feeling sadness or depression related to grief
_____ Health concerns (physical complaints and/or medical problems)
_____ Illegal behaviors (runaway, stealing, fire setting, truancy, etc.)
_____ Non-family relationship problems (co-workers, peers, etc.)
_____ Parent-Child relationship problems (discipline, adoption, single parent, etc.)
_____ Sexual concerns (inappropriate acting out, pornography, etc.)
_____ Sleep problems (nightmares, sleeping too much/too little, etc.)
_____ Suicidal Ideation (thoughts of death, wanting to die)
_____ Unusual behavior (bizarre actions, speech, compulsive behaviors, tics, motor behavior problems, etc)
_____ Other (explain)_____

Briefly describe the problem that has brought you into therapy. _____

_____

_____

Describe what approaches you have currently taken to alleviate the problem. _____

_____

How were you referred?_____

_____

Parent's Signature on behalf of minor child Today's Date