CLIENT INFORMATION

Date ________________

Identification Information for Youth

Name ____DOB _________________________

Address _____________________________ Apt. ____________Home Phone ______________

City __________________________State ____ Zip __________ Work Phone ______________

Employer/School __________________________ Occupation/Studying ___________________

Legal Guardian/Parent Information

Name ____ DOB_____________________
Address _______________________________ Apt. _____________ Home Phone ___________
City __________________________State ________ Zip __________ Work Phone __________
Employer/School ___________________________________ Occupation/Studying __________

Additional Legal Guardian/Parent Information

Name ____ DOB_______________
Address _______________________________ Apt. _____________ Home Phone ___________
City __________________________State ________ Zip __________ Work Phone __________

Employer/School ___________________________________ Occupation/Studying _________

Referral Information

How did you hear about my services?

Please mark the option that applies:
__ Internet
__ Referral from a friend or family member
__ School staff
__ Another mental health professional
__ Other, please specify ____

Family Information

With whom does the youth currently live?

____

	First Name	How frequently does the youth see this person	How does youth get along with this person Please use a 1 to 5 scale with 1 indicating a highly problematic relationship.
Parent/Guardian			
Step parents			
Grandparents			
Uncles/Aunts			
Brothers			
Sisters			

Is there a Family History of:

Depression Suicide Attempts Anxiety Eating Disorders Mental Illness

Violence Sexual Abuse Emotional Abuse Alcoholism/Drug Addiction Chronic Illness

Please explain any chronic illness____

Other____

Medical Information

Primary Physician______________________ Phone: ___________ Date Last Exam ________

Major or Chronic Illnesses/Injuries ____

____

Operations

____

Current Medications	Dosage	Frequency	Effectiveness	Prescribing Physician

Have you experienced any recent changes in any of the following areas?

Sleep Behaviors / Amount of Exercise / Sexual Desire Eating /Appetite / Weight

Substance Use

Tobacco: Does the youth smoke? Yes___ No___

Smoked in the past? Yes___ No___

If yes-Cigarettes/Day ______ Began at what age? ________

If no longer smokes- When did he/she quit? __________

Alcohol: Does the youth consume alcohol? Yes ___ No ____ If so, how much:

Less than 1x/month _____ 1-3x month ____1x week ____ Several x's a week ____ Everyday__

Check all that apply: Beer ______ Wine ______ Hard Liquor _______

Drugs: Do you use any street drugs or misuse prescription drugs? Yes _____ No _____ If yes, list as follows:

Name of Drug	Frequency of use

Counseling Information

Please describe the main concerns that prompted your family to seek services at this time?

____
____
____

How have these concerns evolved over time? ____
____
____

Please indicate what major stressors you have had in the last 12 months

Serious illness or injury Death of a Close Friend or Family Member Major Illness in Family Gain of New Family Member Divorce/Separation Job Change Other

What you would like to be different in your family or with the youth when therapy ends?

____
____
____

Has the youth ever received psychological or psychiatric counseling before? Yes _____ No ____

If so, please describe when, from whom, purpose and the results

____
____
____
____

Has the youth ever been prescribed medication for psychiatric or emotional problem/s? Yes __No

If so, please describe when, prescribing clinician, what medication, for what, and the results

____
____
____

Has the youth ever been hospitalized for a psychiatric or emotional health reason? Yes ___ No __
If so, please describe when, where, for what reason, result _______________________________

____

Has the youth been in a drug or alcohol program? Yes _____ No _____ If yes, how many times ____ If so: When ____________ Inpatient ____ Outpatient _____How Long _______ Outcome ____

Please indicate if the youth has experienced any current or past issues in the following areas:

Physical, Sexual or Emotional Abuse ____
____

Harming self ____
____

Violent behaviors____
____

Mental Illness of Family Member ____
____

Legal Problems ____
____

Suicidal thoughts or behaviors ____
____

Witnessing domestic violence ____
____

Please list the first names of your significant friends and indicate how long you have had these relationships

First Name	How Long	How often do you see this person

Spiritual Resources

How significant a role does spirituality play in your life?

None _____ Somewhat important _____ Significant _____ Very Significant _____

Other

Is there anything else you think I should know about prior to beginning counseling?

Thank you for your time.
I look forward to working with you.