Client's Name: _____ Official Use/Samaritan ID: _____

MINOR CLIENT INFORMATION FORM

The information requested in this form will be kept confidential, and will help your child's client to assist him or her. Please fill out the form with your child's information as completely as you can.

First Name: _____ Last Name: _____ Middle Initial: _____

☐ Male ☐ Female Birth Date: _____ Age: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Racial/Ethnic Identity *(Optional)*: ☐ African-American ☐ Asian-American ☐ Hispanic ☐ Native-American ☐ White/Caucasian ☐ Other: _____

Form Completed By: _____

Referred By: _____

PARENTS

Mother: Last Name: _____ First Name: _____

Please complete address information if different from minor's information provided above:

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address _____ Telephone #1 _____ ☐Home ☐Cell ☐Work Telephone #2 _____ ☐Home ☐Cell ☐Work

Step-Father (if applicable): Last Name: _____ First Name: _____

Father: Last Name: _____ First Name: _____

Please complete address information if different from minor's information provided above:

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address _____ Telephone #1 _____ ☐Home ☐Cell ☐Work Telephone #2 _____ ☐Home ☐Cell ☐Work

Step-Mother (if applicable): Last Name: _____ First Name: _____

Relationship status of biological parents to each other:

☐Married ☐Living Together ☐Engaged ☐Separated ☐Divorced

Is there a custody agreement? ☐No ☐ Yes

If yes, primary physical custodian is: ☐ Mother ☐ Father ☐Joint ☐ Other: _____

If yes, legal custodian is: ☐ Mother ☐ Father ☐Joint ☐ Other: _____

Client's Name: Official Use/Samaritan ID:

ADDITIONAL EMERGENCY CONTACT

Additional emergency contact person: Last Name: First:

Relationship to minor: Telephone:

RELIGIOUS INFORMATION

Is you child being raised in any religious denomination?

☐No ☐Yes

If yes, what denomination/faith tradition?

Place of Worship:

If applicable, child's participation/activities include:

AREAS OF CONCERN:

☐Anxiety	☐Irritability	☐Limited Eye Contact
☐Excessive Worrying	☐Refuses to Follow Directions	☐Overly Eager to Please
☐Irrational Fears for Age	☐Tantrums/Anger Control	☐Excessive Care/Persistence Actions
☐Hypersensitive-Feelings Easily Hurt	☐Destroys Things	☐Compulsive Behaviors
☐Crying Spells	☐Bullying Behavior	☐Level of Energy
☐Being Bullied or Suspicions	☐Physically Hit/Hurts Others	☐Sleep
☐Fear of Embarrassment	☐Defiant: ☐Home ☐School	☐Weight Change
☐Low Self Confidence	☐Interrupts Others	☐Body Image Concern
☐Feelings of Guilt/Worthlessness	☐Attention/Ability to Concentration	☐Bed Wetting
☐Loneliness	☐Difficulty Following Directions	☐Technology ☐Computer ☐Phone
☐Depression	☐Forgetful	☐Excessive Risk Taking-Explain Below
☐Talking about Death/Suicide	☐Lack of Organizational Skills	☐Sexualized Behavior or Acting Out
☐Self-Injurious Behavior	☐Hyperactivity	☐Substance Use ☐Drug ☐Alcohol
☐Recent Death or Loses	☐Easily Distracted	☐Legal Issues-Explain Below
☐Interpersonal Relationships: ☐Parents ☐Teachers ☐Peers/Friends		☐Relationship with God
☐History of Difficulty Separating from Caregiver: ☐Past ☐Current		☐Physical Concerns-Explain Below
☐History of Abuse: ☐Emotional/Mental ☐Physical ☐Sexual		☐Academic Concerns

FAMILY INFORMATION

Is this child adopted? ☐No ☐Yes

If yes, at what age and does the child know that he/she was adopted? ☐No ☐Yes

Circumstances of adoption:

Client's Name: ____________ Official Use/Samaritan ID: ____________

FAMILY INFORMATION (Continued)

Please list child's family members and any other individuals who reside in home of the child's parents.
Please use back of page if additional space is needed

Siblings:

Name:	☐Biological ☐Half ☐Step If applicable, other parent's name: Age: Gender: ☐Male ☐Female Resides with child: ☐Yes ☐Other:
Name:	☐Biological ☐Half ☐Step If applicable, other parent's name: Age: Gender: ☐Male ☐Female Resides with child: ☐Yes ☐Other:
Name:	☐Biological ☐Half ☐Step If applicable, other parent's name: Age: Gender: ☐Male ☐Female Resides with child: ☐Yes ☐Other:
Name:	☐Biological ☐Half ☐Step If applicable, other parent's name: Age: Gender: ☐Male ☐Female Resides with child: ☐Yes ☐Other:
Name:	☐Biological ☐Half ☐Step If applicable, other parent's name: Age: Gender: ☐Male ☐Female Resides with child: ☐Yes ☐Other:
Name:	☐Biological ☐Half ☐Step If applicable, other parent's name: Age: Gender: ☐Male ☐Female Resides with child: ☐Yes ☐Other:

Individuals Other than Siblings Living in Child's Home:

Name:	Relationship:	Gender: ☐Male ☐Female	Age:
Name:	Relationship:	Gender: ☐Male ☐Female	Age:

Significant Changes In Family

Describe any significant changes in family make-up during the child's lifetime (deaths, separations, divorces, moves, marriages, and traumatic events such as fires, car accidents, etc.).

PSYCHOLOGICAL HISTORY

Has your child received counseling in the past? ☐No ☐Yes

If yes, what were the circumstances and the name(s) of the treating therapist(s), organization(s)/facilities and date(s)?

Client's Name: Official Use/Samaritan ID:

MEDICAL HISTORY

Primary Care Physician:

Address:

Telephone: Fax: Date of Last Visit:

Specialization Doctors (Name, Specialty & Date(s) of last visit(s):

Current physical illness/ symptoms/pain?

Current Medications: ☐ None ☐ Yes (List Below)

Medication	Dosage	Frequency	Start Date	Prescriber's Name and Title

Allergies: ☐ None ☐ Yes If yes, please list allergies:

Hospitalizations/Surgeries/Psychiatric Hospitalization: include reason(s) and date(s):

General description of diet/nutritional habits:

PRENATAL & BIRTH INFORMATION

Was pregnancy planned? ☐ No ☐ Yes

Were there stressors, difficulties, concerns during pregnancy and following birth? ☐ No ☐ Yes If yes, please explain:

EDUCATIONAL INFORMATION

Client's Name: Official Use/Samaritan ID:

Current School Name: District Name:

☐Public School ☐Private School ☐Alternative Education Placement ☐ Home School ☐ Other:

Current homeroom teacher: Grade: Grades repeated:

Classroom placement/services (check all that apply):

☐Regular classroom ☐Learning support ☐Emotional support ☐Life support ☐Autistic support

☐Therapeutic staff support (TSS) ☐Advanced placement classes ☐Gifted placement ☐ Other:

Does child have a current IEP or a 504 Plan? ☐No ☐Yes

If yes, grade initiated. Reason/diagnosis:

Is your child currently seeing the school guidance counselor or psychologist? ☐No ☐Yes

Additional information, such as changes in schools, academic, behavior or social concerns can be added.

ACTIVITIES

Is your child involved in any community-based or after school activities? ☐No ☐Yes

If yes, list and describe involvement.

STRENGTHS (Check all that apply)

☐Affectionate	☐Decisive	☐Expressive	☐Grateful	☐Optimistic
☐Analytical	☐Determined	☐Flexible	☐Honest	☐Patient
☐Compassionate	☐Discerning	☐Forgiving	☐Humble	☐Persuasive
☐Confident	☐Disciplined	☐Frank	☐Independent	☐Punctual
☐Content	☐Eager to Please	☐Friendly	☐Loyal	☐Resourceful
☐Courageous	☐Efficient	☐Frugal	☐Neat	☐Sensitive
☐Creative	☐Enthusiastic	☐Generous	☐Objective	☐Thorough
☐Other:				

ACKNOWLEDGEMENT: Please sign and date this document attesting that the information you have written on this form is accurate to the best of your knowledge. Please add your signature and the date below after printing document.

_____ _____

MINOR LEGAL GUARDIAN'S SIGNATURE DATE

Client's Name: _____ Official Use/Samaritan ID: _____

Information on this page is used for bookkeeping and statistical purposes.

Client's Name: _____ Date: _____

Guardian completing form: _____

Street Address: _____

City: _____ State: _____ Zip: _____

What type of counseling are you seeking? ☐Individual ☐Family ☐Group ☐Spiritual Direction

Do we have permission to send you a form evaluating our services to the above address? ☐No ☐Yes

Would you like to be on our mailing list and receive our newsletter? ☐No ☐Yes

E-Mail Address: _____

How did you hear about the Samaritan Counseling Center?
Please complete the most appropriate response:

☐Phone Book

☐Pastor (name): _____ Church: _____

☐Physician (name): _____

☐Lawyer (name): _____

☐School Counselor (name): _____ School: _____

☐Managed Care Company (Insurance): _____

☐Friend (optional): _____

☐Internet (optional-additional information): _____

☐Other: _____

If the person who referred you to the Samaritan Center is a professional, we would like to let them know that you followed through on their recommendation.

Do we have your permission to send them a letter thanking them for referring you? ☐No ☐Yes

Please add your signature and the date below after printing document.

_____ _____

MINOR LEGAL GUARDIAN'S SIGNATURE DATE