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Client Information Sheet for Children and Teens

☐ Male ☐ Female

Client Name:______________________________Date of Birth:__________Age:______

Address:______________________________City:____________Zip:____________

Parent information:

Parent Name: ______________________
Address: ______________________
City: ____________Zip:__________
Date of birth:__________ Age:__________
Occupation: ______________________

Home Phone:______________________
Work Phone:______________________
Cell Phone:______________________

Parent Name: ______________________
Address: ______________________
City: ____________Zip:__________
Date of birth:__________ Age:__________
Occupation: ______________________

Home Phone:______________________
Work Phone:______________________
Cell Phone:______________________

Party responsible for client (if other than parent):

Name: ____
Address: ______________________City:____________Zip:__________
Phone number:______________________Relationship to you:__________

Marital status of parents:

☐Single ☐Married ☐Separated ☐Widowed ☐Cohabitating ☐Remarried ☐Divorced

Other children living in the home:

Name:______________________Date of Birth:____________ Age:______
Name:______________________Date of Birth:____________ Age:______
Name:______________________Date of Birth:____________ Age:______
Name:______________________Date of Birth:____________ Age:______
Name:______________________Date of Birth:____________ Age:______

School information:

Name of school:______________________________Grade: ____________
Address: ______________________City:____________Zip:__________
School phone number:____________________School fax number:____________________

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Developmental history:

Parents: Complications during pregnancy (illness, stressors, etc)?____

____

Parents: Difficulties during childbirth?____

____

Developmental milestones:

Age first walked: ______________Age first talked:_______________Age potty-trained:____________

Major issues or trauma as an infant or toddler (0-3): ____

____

____

____

Other developmental issues:____

Health insurance coverage:

Name of insurance company:_________________________________Phone:_____________________

Plan or policy #: _____________________Certificate #__________________Individual ID:___________

Name of insured if different than client:____

Medication:

Name/dosage: ______________________Prescribed for:________________Doctor:________________

Name/dosage: ______________________Prescribed for:________________Doctor:________________

Name/dosage: ______________________Prescribed for:________________Doctor:________________

Allergies:____

Current goals and concerns (list your reasons for coming to counseling):

1. ____
2. ____
3. ____
4. ____
5. ____

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Have there been any major changes in:

- ☐ Eating habits
- ☐ Living arrangements (moved)
- ☐ Sleeping habits
- ☐ Social activities
- ☐ Family responsibilities
- ☐ Exercise habits
- ☐ School responsibilities
- ☐ Physical health
- ☐ Other:________________________

Indicate each stressor the child or family has experienced during the last six months:

- ☐ Loss of job
- ☐ Hospitalization
- ☐ Stopped smoking
- ☐ Pregnancy
- ☐ Retirement
- ☐ Suicidal thoughts
- ☐ Suicide attempts
- ☐ Sexual difficulties
- ☐ New family member
- ☐ Feelings of worthlessness
- ☐ Panic or anxiety attacks
- ☐ Death of a close friend
- ☐ Death of close family member
- ☐ Financial difficulties
- ☐ Arrest or pending charges
- ☐ Incarceration/ conviction
- ☐ Major accident/injury/ illness
- ☐ Involved in lawsuit
- ☐ Increase in number of arguments
- ☐ Outstanding personal achievement
- ☐ Anger management problems
- ☐ Other self-control problems
- ☐ Alcohol or drug problems
- ☐ Significant weight loss/ gain
- ☐ Significant changes in memory or attention

Social and emotional health:

☐ Never	☐ Sometimes	☐ Often	My child daydreams a lot.
☐ Never	☐ Sometimes	☐ Often	My child has difficulty focusing or concentrating.
☐ Never	☐ Sometimes	☐ Often	My child seems depressed.
☐ Never	☐ Sometimes	☐ Often	My child is impulsive.
☐ Never	☐ Sometimes	☐ Often	My child has nightmares.
☐ Never	☐ Sometimes	☐ Often	My child loses his or her temper easily.
☐ Never	☐ Sometimes	☐ Often	My child has difficulty making friends.
☐ Never	☐ Sometimes	☐ Often	My child is disorganized.
☐ Never	☐ Sometimes	☐ Often	My child is hyperactive.
☐ Never	☐ Sometimes	☐ Often	My child blames others for his or her mistakes.
☐ Never	☐ Sometimes	☐ Often	My child gets along with his or her teachers.
☐ Never	☐ Sometimes	☐ Often	My child is a bullying victim.
☐ Never	☐ Sometimes	☐ Often	My child bullies other children.

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Relationships with family members and friends:

Describe your relationship with your child: ____
____
____
____

Describe your child's relationships with his or her siblings:_______________________________
____
____
____

Describe your child's relationships with his or her peers:__________________________________
____
____
____

Previous counseling or therapy:

☐ Individual	☐ Group	☐ Psychologist	☐ LPCC
☐ Couple	☐ Outpatient	☐ Psychiatrist	☐ LCSW
☐ Family	☐ Inpatient	☐ MFT	☐ Other:______________

Name of provider: ____________________________________How long?___________________

Reason for treatment: ______________________________Results:_________________________

Other information you think I should know: ____
____
____
____
____
____

Signatures:

I have answered these questions to the best of my knowledge.

Parent signature:____Date:_________________

Parent signature:____Date:_________________

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