Minor Client Information Form

Please complete this information form for your child in collaboration with your child's other parent/guardian. If your child is mature enough to participate in completing this form or is 12 years old or older, please review the questions together. Completing this form thoroughly will help us identify what we should address in therapy and will save us time in getting started.

Name of Minor Client:_____

Birth date: ____/____/_____ Gender: M or F or _____

Address:_____

City:_____ State:_____Zip Code: _____

Email Address: _____ Ethnicity: _____

	Parent #1	Parent #2
Name:		
Phone #:		
E-mail:		
Address:		

Parent #1: Name _____
May I leave detailed messages on the phone numbers listed above? Yes / No
May I send e-mails that include information related to your child's treatment? Yes / No
May I mail you treatment-related information at your address? Yes / No

Parent #2: Name _____
May I leave detailed messages on the phone numbers listed above? Yes / No
May I send e-mails that include information related to your child's treatment? Yes / No
May I mail you treatment-related information at your address? Yes / No

Parents divorced? Yes / No

If yes, what is the custody arrangement?_____

_____

Other important family members and members of household:

Name: _____ Age: ____ Relationship: _____

Name: _____ Age: ____ Relationship:_____

Name: _____ Age: ____ Relationship: _____

Name: _____ Age: ____ Relationship:_____

Who else might you want to be involved in your child's therapy (family member, school)?

_____

Emergency Contact: _____ Phone: _____

Emergency Contact's Relationship to Minor: _____

Primary Care Physician:_____Phone:_____

Address: _____

Psychiatrist: _____Phone:_____

Address: _____

Has your child participated in therapy or counseling in the past? Yes or No
If yes, tell me about their experience of therapy, the time period, and reason for treatment:

_____

_____

Physical health (briefly describe any concerns or health issues, history of surgeries):

_____

_____

Does your child have any problems with eating, body weight, or body image? Yes / No

Does your child have any history of binging, purging, or restricting behaviors? Yes / No

Please describe any yes response:_____

_____

Have you addressed these physical health concerns with a doctor? Yes / No / N/A

Do you or your child have concerns about their sexual development or sexual behaviors?

_____

_____

Has your child ever been hospitalized? If so, please note the dates/location and reason why:

_____

_____

Please list your child's medications:_____

_____

Does your child have a learning disability, developmental condition, or delays meeting milestones? Yes / No

_____

_____

Please describe any physical or mental health conditions that affect members of your household or run in your family:_____

_____

Name of School:_____ Grade level:_____

What grades does your child typically receive? _____

Has your child been expelled or suspended? Yes / No Do they cut classes? Yes / No

Are they in Honors or AP classes? Yes / No

How does the school/teacher view your child? (e.g. hyperactive, timid, achiever, procrastinator)

_____

How would you describe your child's functioning in school (relationships with teachers/peers, attendance, homework)? _____

_____

_____

How would you describe your child's friendships and social skills?_____

_____

_____

Communication skills (briefly describe strengths and/or concerns):

_____

_____

Play/Recreation/Fun (briefly describe your child's hobbies or interests):

_____

_____

How much time do you spend together as a family per week?_____

Do you have any concerns about technology use? (i.e. TV, Computer, Phone, Tablet, etc.)

_____

How do you monitor your child's use of technology and social media? _____

_____

What spiritual/religious beliefs does your child or family have that would be helpful for me to know?

_____

_____

What would you like me to know about your child and your family's cultural identity?_____

_____

_____

Has your child or your family experienced any traumatic events (directly or indirectly)?

Has your child been abused, or is there a concern of potential abuse (physical, sexual, verbal)?

Please share any violent behavior, hitting, pushing, shoving, physically restraining another person, or intimidation that are a concern for your child or your family:

Has your child experienced thoughts of wanting to harm themselves or harmed themselves in the past (e.g. cutting, head banging, punching themselves)? Yes or No If yes, please explain:

Has your child experienced thoughts of wanting to kill themselves in the past or attempted to kill themselves? Yes or No If yes, please explain:

Describe your child's use of marijuana, alcohol, and other drugs (how much, how often, if use is increasing or decreasing, and if your child has ever had problems with friends, family, or the law while using substances):

Does your child engage in gambling (e.g. in apps) or excessive spending? Yes or No

Please describe any significant stressors that are affecting your child or your family at this time:

Please describe some of your child's and family's strengths and resources:

What would you like your child to gain from our work together (therapy goals)?

When therapy is successful for your child, how will we know?

What reservations do you have, if any, about your child beginning therapy?:

How motivated are you to support your child in therapy at this time, where 10 is the most motivated and 1 is the least? _____(Parent 1) _____(Parent 2)

How motivated is your child to be in therapy at this time? Rating (1 to 10):_____

My signature indicates that I have completed this document and the information it contains is truthful.

_____	_____	_____
Parent Name (Printed)	Parent Signature	Date
_____	_____	_____
Parent Name (Printed)	Parent Signature	Date
_____		_____
Child Signature (if mature enough to participate or age 12 or older)		Date