Client History-Minor

CHILD'S INFORMATION

Name	DOB	Sex
Home Phone May we leave a message at this number?	Cell Phone: May we leave a message at this number? May we text you?	Email: May we contact you via email?
Address		Referred by:

CHILD'S MOTHER

Name	DOB	
Home Phone May we leave a message at this number?	Cell Phone: May we leave a message at this number? May we text you?	Email: May we contact you via email?
Address	Marital Status	Employer

CHILD'S FATHER

Name	DOB	
Home Phone May we leave a message at this number?	Cell Phone: May we leave a message at this number? May we text you?	Email: May we contact you via email?
Address	Marital Status	Employer

Insurance Carrier	Primary Insured's Name	DOB
Primary Insured's Address	Primary Insured's Phone	

Please list who has legal guardianship of this child:

If the parents are separated, divorced, or widowed please explain when this occurred.

If the parents are separated or divorced, please explain the custody agreement.
**If there has been legal action and/or the child's biological parents are not living together, please describe the custody agreement below. Please note that you are required to provide the most recent copies of relevant court paperwork available.*

If one of the parents is not living in the child's primary home, please explain the frequency of contact.

Please list all persons living in the child's primary home:

Name	**Relationship**	**Age**	**Gender**	**Highest Degree/Grade Completed**

If any immediate family member (e.g. parent/sibling) is living elsewhere, please list:

Name	**Relationship**	**Age**	**Gender**	**Highest Degree/Grade Completed**

Educational Background
What is the last grade the child has completed?

Where does the child attend school?

What is the child's GPA/grades?

Does the child have an IEP? If yes, please explain.

Does the child have behavioral problems at school? If yes, please explain.

History of Mental Health Treatment
Previous counseling or psychiatric treatment:

Agency:

Dates:

Diagnosis Given:

Medications:

Family Mental Health History
Has anybody in your family been diagnosed with a mental illness or sought mental health treatment? If yes, please state relationship and diagnosis.

Has anybody in your family ever attempted or completed suicide? If yes, please explain.

Health Information
Describe your child's health:

Does your child have any chronic conditions?

Does your child have any allergies?

Current medications and dosages:

Primary Physician:

Phone Number:

Fax Number:

Social and Family History

How does your child get along with siblings and parents?

How does your child get along with other children his/her age?

Do you have any concerns about the following? If yes, please explain.
Alcohol/drug use?

Sexual behaviors?

Criminal behaviors?

Runaway?

Has the child ever been arrested? If yes, please explain.

Has your family ever been a part of a Department of Child and Family Services investigation?
If yes, please explain and provide the outcome (substantiated or unsubstantiated).

Has anyone in the family ever been charged or convicted of a sexual offense?
If yes, please explain:

What are your primary concerns that you are seeking help for?

When did you first become concerned about your child?

What have you already tried to do?

What do you hope to accomplish through your counseling experience?

What do you consider the child's challenges?

What do you consider the family's challenges?

What do you consider the child's strengths?

What do you consider the family's strengths?

Do you consider yourself to be spiritual or religious? If so, briefly describe your faith or beliefs.

Is there any other information that is important for the counselor to know?

Parent Rating Scale

Each rating should be considered in the context of what is appropriate for the age of your child.

Frequency Code: 0 = Never 1 = Occasionally 2 = Often 3 = Very Often

1. Does not pay attention to details or makes careless mistakes, for example homework 0 1 2 3
2. Has difficulty sustaining attention to tasks or activities 0 1 2 3
3. Does not seem to listen when spoken to directly 0 1 2 3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand) 0 1 2 3

5. Has difficulty organizing tasks and activities 0 1 2 3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort 0 1 2 3
7. Loses things necessary for tasks or activities (school assignments, pencils or books) 0 1 2 3
8. Is easily distracted by extraneous stimuli 0 1 2 3
9. Is forgetful in daily activities 0 1 2 3
10. Fidgets with hands or feet or squirms in seat 0 1 2 3
11. Leaves seat when remaining seated is expected 0 1 2 3
12. Runs about or climbs excessively in situations when remaining seated is expected 0 1 2 3
13. Has difficulty playing or engaging in leisure/play activities quietly 0 1 2 3
14. Is “on the go” or often acts as if “drive by a motor” 0 1 2 3
15. Talks too much 0 1 2 3
16. Blurts out answers before questions have been completed 0 1 2 3
17. Has difficulty waiting his/her turn 0 1 2 3
18. Interrupts or intrudes on others (e.g., butts into conversations or games) 0 1 2 3
19. Argues with adults 0 1 2 3
20. Loses temper 0 1 2 3
21. Actively defies or refuses to comply with adults’ requests or rules 0 1 2 3
22. Deliberately annoys people 0 1 2 3
23. Blames others for his or her mistakes or misbehaviors 0 1 2 3
24. Is touchy or easily annoyed by others 0 1 2 3
25. Is angry or resentful 0 1 2 3
26. Is spiteful and vindictive 0 1 2 3
27. Bullies, threatens, or intimidates others 0 1 2 3
28. Initiates physical fights 0 1 2 3
29. Lies to obtain goods for favors or to avoid obligations (i.e., “cons” others) 0 1 2 3
30. Is truant from school (skips school) without permission 0 1 2 3
31. Is physically cruel to people 0 1 2 3
32. Has stolen items of nontrivial value 0 1 2 3
33. Deliberately destroys others’ property 0 1 2 3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun) 0 1 2 3
35. Is physically cruel to animals 0 1 2 3
36. Has deliberately set fires to cause damage 0 1 2 3
37. Has broken into someone else’s home, business, or car 0 1 2 3
38. Has stayed out at night without permission 0 1 2 3
39. Has run away from home overnight 0 1 2 3
40. Has forced someone into sexual activity 0 1 2 3
41. Is fearful, anxious, or worried 0 1 2 3
42. Is afraid to try new things for fear of making mistakes 0 1 2 3
43. Feels worthless or inferior 0 1 2 3
44. Blames self for problems, feels guilty 0 1 2 3
45. Feels lonely, unwanted, or unloved: complains that “no one loves him/her” 0 1 2 3
46. Is sad, unhappy, or depressed 0 1 2 3
47. Is self-conscious or easily embarrassed 0 1 2 3

*Please have the child complete this page if aged 13 or over.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Feeling down, depressed, irritable, or hopeless?	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things?	Not at all	Several Days	More than half the days	Nearly every day
Trouble falling asleep, staying asleep, or	Not at	Several	More than	Nearly

sleeping too much?	all	Days	half the days	every day
Poor appetite, weight loss, or overeating?	Not at all	Several Days	More than half the days	Nearly every day
Feeling tired, or having little energy?	Not at all	Several Days	More than half the days	Nearly every day
Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?	Not at all	Several Days	More than half the days	Nearly every day
Trouble concentrating on things like school work, reading, or watching TV?	Not at all	Several Days	More than half the days	Nearly every day
Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?	Not at all	Several Days	More than half the days	Nearly every day
Thoughts that you would be better off dead, or of hurting yourself in some way?	Not at all	Several Days	More than half the days	Nearly every day

In the past year have you felt depressed or sad most days, even if you felt okay sometimes?

Yes No

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life? Yes No

Have you ever, in your whole life, tried to kill yourself or made a suicide attempt?

Yes No

*Please have the child complete if aged 13 or over.

While you were growing up, in the first 18 years of your life:

Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you?	Yes	No
Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?	Yes	No
Did an adult or person at least 5 years older than you ever… Touch or fondle	Yes	No

you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?		
Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?	Yes	No
Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	Yes	No
Were your parents ever separated or divorced?	Yes	No
Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit at least a few minutes or threatened with a gun or knife?	Yes	No
Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	Yes	No
Was a household member depressed or mentally ill, or did a household member attempt suicide?	Yes	No
Did a household member go to prison?	Yes	No

Client History-Adult

CLIENT

Name	DOB	
Home Phone May we leave a message at this number?	Cell Phone: May we leave a message at this number? May we text you?	Email: May we contact you via email?
Address	Marital Status	Employer

Insurance Carrier	Primary Insured's Name	DOB
Primary Insured's Address	Primary Insured's Phone	

Please list all persons living your primary home:

Name	**Relationship**	**Age**	**Gender**	**Highest Degree/Grade Completed**

If any immediate family member (e.g. parent/sibling) is living elsewhere, please list:

Name	**Relationship**	**Age**	**Gender**	**Highest Degree/Grade Completed**

Educational Background

What is the highest grade/degree you have completed?

If you currently attend school, what school do you attend?

What is your GPA?

History of Mental Health Treatment
Previous counseling or psychiatric treatment:

Agency:

Dates:

Diagnosis Given:

Medications:

Family Mental Health History
Has anybody in your family been diagnosed with a mental illness or sought mental health treatment? If yes, please state relationship and diagnosis.

Has anybody in your family ever attempted or completed suicide?

Health Information
Describe your health:

Do you have any chronic conditions?

Do you have any allergies?

Current medications and dosages:

Do you engage in any of the following activities? If yes, please list type, amount, and frequency of use.

Drink alcohol?

Smoke cigarettes?

Use other substances?

Primary Physician:

Phone Number:

Social and Family History

How do you get along with siblings and parents?

Have you ever been arrested? If yes, please explain.

Have you ever been charged or convicted of a sexual offense? If yes, please explain:

What are your primary concerns that you are seeking help for?

When did you first notice these concerns?

What have you already tried to do?

What do you hope to accomplish through your counseling experience?

What do you consider the your strengths?

What do you consider your challenges?

Do you consider yourself to be spiritual or religious? If so, briefly describe your faith or beliefs.

Is there any other information that is important for the counselor to know?

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Feeling down, depressed, irritable, or hopeless?	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things?	Not at all	Several Days	More than half the days	Nearly every day
Trouble falling asleep, staying asleep, or sleeping too much?	Not at all	Several Days	More than half the days	Nearly every day
Poor appetite, weight loss, or overeating?	Not at all	Several Days	More than half the days	Nearly every day
Feeling tired, or having little energy?	Not at all	Several Days	More than half the days	Nearly every day
Feeling bad about yourself — or feeling that you are a failure, or that you have let	Not at all	Several Days	More than half the days	Nearly every day

yourself or your family down?				
Trouble concentrating on things, such as reading the newspaper or watching television	Not at all	Several Days	More than half the days	Nearly every day
Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?	Not at all	Several Days	More than half the days	Nearly every day
Thoughts that you would be better off dead, or of hurting yourself in some way?	Not at all	Several Days	More than half the days	Nearly every day

In the past year have you felt depressed or sad most days, even if you felt okay sometimes?

Yes No

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life? Yes No

Have you ever, in your whole life, tried to kill yourself or made a suicide attempt?

Yes No

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Feeling nervous, anxious or on edge	Not at all	Several Days	More than half the days	Nearly every day
Not being able to stop or control worrying	Not at all	Several Days	More than half the days	Nearly every day
Worrying too much about different things	Not at all	Several Days	More than half the days	Nearly every day
Trouble relaxing	Not at all	Several Days	More than half the days	Nearly every day
Being so restless that it is hard to sit still	Not at all	Several Days	More than half the	Nearly every day

			days	
Becoming easily annoyed or irritable	Not at all	Several Days	More than half the days	Nearly every day
Feeling afraid as if something awful might happen	Not at all	Several Days	More than half the days	Nearly every day

While you were growing up, in the first 18 years of your life:

Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you?	Yes	No
Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?	Yes	No
Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?	Yes	No
Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?	Yes	No
Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	Yes	No
Were your parents ever separated or divorced?	Yes	No

Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit at least a few minutes or threatened with a gun or knife?	Yes	No
Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	Yes	No
Was a household member depressed or mentally ill, or did a household member attempt suicide?	Yes	No
Did a household member go to prison?	Yes	No