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CLIENT INFORMATION FORM – ADOLESCENT
PLEASE USE BLACK OR BLUE INK

GENERAL INFORMATION

Today's Date _____

Client's Name _____ Referred by _____

Address _____City/State _____ Zip _____ Home Phone ( ) _____

Client Cell Phone ( ) _____ Client e-mail address: _____

Birthdate _____ Age _____ Gender Identity _____ Pronouns Used _____

Parent/Guardian Name _____ Occupation _____ Employer _____

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Parents' Cell Phones _____ Parents' emails _____

SCHOOL INFORMATION (Child/Adolescent)

Name of minor's school _____ City _____Phone ( ) _____

Grade ____ School Counselor _____ Grades in current classes _____

Favorite Subjects _____ Least Favorite _____

Extracurricular Activities _____

PERSONAL / FAMILY INFORMATION

Parents' Marital Status _____

If divorced or not with parent, who has legal custody? _____ physical custody? _____

what is visitation arrangement? _____ Names/ages of siblings _____

Emergency Contact: Name _____ Relationship _____ Phone(s) ( ) _____

Pregnancy and Birth History: Full Term _____ Premature _____ Adopted _____

Any unusual circumstances or difficulties with the pregnancy or post-partum? _____

FINANCIAL INFORMATION

Preferred Payment: ___ Cash ___ Check (in person only) ___ PayPal ___ Credit Card

Credit Card Authorization (separate form) (Credit Card Billing will appear as THERAPY PARTNER)

OVER

CONFIDENTIAL INFORMATION (if age 12 or older, will be shared with parent ONLY if life-threatening)

Are you CURRENTLY seeing another psychotherapist or counselor? ____ If so: Phone ( ) _____

Name _____ For how long? _____ For what purpose(s)? _____

Have you PREVIOUSLY been in psychotherapy or counseling? ____ When? _____ For how long? _____

For what purpose(s)? _____What worked/did not work for you in that therapy?_____

Purpose for today's consultation: _____

_____ Learning disabilities/academic problems? _____

_____ Alcohol, drug, or tobacco dependence or frequent use? _____

_____ Eating disorder or Medical Problem? _____

_____ Legal problems? _____

_____ Self-injury or other addictive or compulsive behavior(s)? _____

_____ Depression or suicidal thoughts/attempts? _____

_____ Anxiety or panic attacks? _____

_____ Anger, arguments, domestic violence? _____

_____ Problems with boy/girlfriends or sexual matters? _____

_____ Other? _____

Please list stressful situations in your history (accident, hospitalization, separation from loved ones, traumatic event, etc.)
_____

What have you found has been helpful to you when you have felt depressed, anxious, etc.?
_____

MEDICATIONS AND MEDICAL HISTORY

Please list ALL prescription medications you are CURRENTLY taking:
_____

Please list any PREVIOUS medications you have taken for psychological purposes:
_____

How much/how often do you:

smoke cigarettes/vape _____ drink alcohol _____ drink caffeine (coffee/cola/chocolate) _____

use any other drugs (marijuana, cocaine, ecstasy, etc) _____

Date of last medical exam _____ Doctor's Name _____ Phone ( )_____

Other physical or medical conditions: _____

Tell me something else about you: _____