

Jaelline Jaffe, Ph.D.
4910 Van Nuys Blvd., Suite 301, Sherman Oaks, CA 91403

CLIENT INFORMATION FORM – CHILD/ADOLESCENT

GENERAL INFORMATION

Today's Date _____

Client's Name _____ Referred by _____

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

Cell Phone () _____ e-mail address: _____

Birthdate _____ Age _____ Social Security # _____

Parent/Guardian Name _____ Occupation _____ Employer _____

Parent/Guardian Name _____ Occupation _____ Employer _____

Parent Cell Phone or other contact info _____

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) () _____

FINANCIAL INFORMATION Preferred Pymt: ___ Cash ___ Check ___ PayPal ___ Credit Card

Card Type ___ VISA ___ MC ___ Discover **(Credit Card Billing will appear as THERAPY PARTNER)**

Card # _____ Exp Date _____

Signature _____

Credit Card Billing Info ___ SAME as client above ___ DIFFERENT from above (complete below)

Name _____ Address _____

City _____ State _____ Zip _____

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 _____ 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: