

CLIENT INFORMATION FORM – MINORS

Client Name _____ Date of Birth _____
 Address _____ Gender _____
 _____ Sexual Orientation _____
 City _____ Race/Ethnicity _____
 State _____ Zip _____ Religion _____
 Email _____ Leave Msg? Relationship Status Single Partnered Married
 Home Phone _____ Leave Msg? School _____
 Cell Phone _____ Leave Msg? Who referred? _____

PARTY RESPONSIBLE FOR PAYMENT

Name _____ Home Phone _____
 Relationship to Client _____ Work Phone _____
 Address _____ Cell Phone _____
 _____ Email _____
 City _____ State _____ Zip _____ Send monthly statements: By Email By US Mail

EMERGENCY CONTACTS

Name _____	Name _____
Relationship to Client _____	Relationship to Client _____
Home Phone _____ Leave Msg? <input type="checkbox"/>	Home Phone _____ Leave Msg? <input type="checkbox"/>
Work Phone _____ Leave Msg? <input type="checkbox"/>	Work Phone _____ Leave Msg? <input type="checkbox"/>
Cell Phone _____ Leave Msg? <input type="checkbox"/>	Cell Phone _____ Leave Msg? <input type="checkbox"/>
Email _____ Leave Msg? <input type="checkbox"/>	Email _____ Leave Msg? <input type="checkbox"/>

CURRENT PROVIDERS

Name _____	Name _____
Provider Type _____	Provider Type _____
City _____ State _____	City _____ State _____
Phone Number _____	Phone Number _____
Last Visit _____	Last Visit _____
Would you like me to coordinate care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Would you like me to coordinate care? <input type="checkbox"/> Yes <input type="checkbox"/> No

CURRENT MEDICATIONS

Medication	Dosage	Provider Contact Information

What are your primary reasons for seeking services at this time? Please describe symptoms, severity, and duration as appropriate.

What are your goals for treatment?

PREVIOUS PSYCHOTHERAPY TREATMENT

Table with 3 columns: Name of Provider, Dates, Contact Information. Contains 3 empty rows.

MEDICAL HISTORY

Normal Developmental History?
Chronic Medical Conditions?
Hospitalizations?
Head Injuries?
Current Medical Concerns?

FAMILY HISTORY

Table with 3 columns: Family Member, Medical History, Psychological History. Rows include Siblings, Mother, Maternal Family, Father, Paternal Family.

Parent/Guardian Signature _____ Date _____

Client Signature _____ Date _____