

Form 6. Client Contact and Information Form - Minors

Demographic Information

Name: _____ Date: _____

DOB: _____ Age: _____ Birthplace: _____

Gender: _____ Race: _____ Ethnicity: _____

Address: _____

Name of parent(s)/guardian(s) who have legal custody of child.

** Address if parent/guardian lives in another residence:*

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number(s): _____

Is it ok to leave a voicemail? YES NO

Email Address: _____

Is it ok to email you? YES NO

How were you introduced to us? _____

How Have We Come to Meet?

What are the 3 biggest concerns you have for your child right now? How long have each been going one?

1. _____
2. _____
3. _____

What do you think your child would say their biggest concern(s) is/are?

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What solutions (helpful or unhelpful) have you tried to resolve the above concerns?

Have you or your child(ren) had therapy in the past? If so, please provide treatment providers names, dates of service, what your child was seen for, and results.

What are your expectations from therapy and the therapist?

List concrete changes you would like to see happen during the course of therapy.

What other things would you like to see change in your life and your family's life?

Do you foresee any obstacles to achieving your goals/changes?

How long will therapy need to last to achieve the changes/goals you want? Write down a target date.

List 5 strengths about your child, give examples of each.

1.

2.

3.

4.

5.

Medical Background

Has your child ever received psychiatric services before? YES NO
 If yes, how long ago, with whom, for what, and results.

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Many parents have opinions on psychiatric medications, what are yours?

Does your child have any allergies?(food, environmental, medicinal, animal, etc.)

Any current or past medical issues, hospitalizations, accidents, injuries, or surgeries? If yes, for what?

Is your child presently under a physician’s care? If so, for what?

List medications (over the counter & prescribed), nutritional or herbal supplements, alternative treatments (acupuncture, chiropractic, etc.) your child is taking/doing and reasons.

Tell us about the pregnancy of your child (full term, preemie, any complications during pregnancy or at birth, environment and situations during pregnancy and birth).

Tell us about your child’s development milestones (delayed, on time, early).

Important Questions We Must Ask

Has your child ever had thoughts of killing themselves? YES NO
If yes, please explain.

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Has your child ever planned on killing themselves? YES NO
If yes, please explain.

Has your child ever attempted to kill themselves? YES NO
If yes, please explain.

Has anyone in your family or close to you died by suicide? YES NO
If yes, please explain.

Has your child ever felt like they wanted to seriously hurt or kill someone else?
If yes, please explain. YES NO

Do you have weapons in your home or access to weapons? YES NO
If yes, who has access to them and what are the safety protocols around them?

Is there any past or present abuse or violence? YES NO
If so, please explain.

Is your child currently using any illegal drugs or is the reason you are seeking therapy services substance related?

Has your child ever witnessed or experienced a trauma? Have reoccurring nightmares, flashbacks, or avoids anything that is uncomfortable or painful? If so, please explain.

Are you concerned your child may see or hear things that don't appear to be real? If so, please explain.

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Has your child even been arrested, been involved with the juvenile justice system, or is engaging in behaviors that put them at risk? If so, please explain?

Do you have any concerns about your child's sexuality, gender, or sexual development?

Education, Responsibility, Recreation and Leisure

What school does your child attend? _____

What grade is your child in? _____

How are your child's grades? _____

Has your child ever been held back or receive specialized academic services? If so, for what?

What concerns if any do you have about your child's education or schooling (grades, peers, relationships with teachers, etc.)?

What would your child say they like and dislike about school.

Likes: _____

Dislikes: _____

What responsibilities does your child have at home?

If your child is 15 years of age and above what skills do you think your child needs to be independent? How are they learning them? What else do they need to gain independence?

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What other responsibilities or skills would you like to see your child have/achieve?

Does your child have their own cell phone? YES NO

What are the rules around your child's cell phone use? Who enforces those rules?

Understanding Your Family

** Space left for therapist to draw family tree (genogram)*

Parent's marital status

Married Divorced Never Married Separated Domestic Partners Widowed

If 1 or both parents are absent, if so for how long and reason for absences.

If parents are not together, please describe the parents' relationship with one another.

Who lives in the house with the child?

If parents are not together who lives in the other house with the child?

Does your family have any pets? If yes, names, types and relationship to each pet.

List 5 or more strengths of your family.

Is there anything that gets in the way of your family being the way you want it to be?

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