

**NEW CLIENT INFORMATION FORM: ADOLESCENT**

*\*\*This form to be completed by a parent or guardian of the adolescent client\*\**

**BACKGROUND INFORMATION**

**DATE** \_\_\_\_\_

Client's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Client's Address: \_\_\_\_\_

Client's Home Phone: \_\_\_\_\_ Client's Cell Phone: \_\_\_\_\_

Parent 1 Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Parent 2 Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Child lives with: \_\_\_\_\_

If parents are divorced, describe custody arrangements: \_\_\_\_\_

Emergency Contact Person (other than parent): \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

**CLIENT EDUCATION INFORMATION**

Current Grade: 7 8 9 10 11 12 Other: \_\_\_\_\_

Name of School: \_\_\_\_\_

School Address: \_\_\_\_\_

Name of School Counselor: \_\_\_\_\_

Problems in School? \_\_\_\_\_

**CLIENT MEDICAL INFORMATION**

Primary Care Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Is your child currently receiving medical treatment? Yes No

If Yes, Please Specify: \_\_\_\_\_

List any previous conditions, serious illnesses, or injuries that your child has been diagnosed with or treated for: \_\_\_\_\_

Current Medications:	Dosage:	Taking for:

**PARENT 1 INFORMATION**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Can you be contacted at work?    No    Yes                      Work Phone: \_\_\_\_\_

Are you currently receiving medical treatment?    No    Yes

Describe any health issues that require ongoing care: \_\_\_\_\_

Previous counseling/therapy?    No    Yes                      When? \_\_\_\_\_

With whom and for how long? \_\_\_\_\_

**PARENT 2 INFORMATION**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Can you be contacted at work?    No    Yes                      Work Phone: \_\_\_\_\_

Are you currently receiving medical treatment?    No    Yes

Describe any health issues that require ongoing care: \_\_\_\_\_

Previous counseling/therapy?    No    Yes                      When? \_\_\_\_\_

With whom and for how long? \_\_\_\_\_

**FAMILY INFORMATION**

Does/has anyone in your family had problems with drug or alcohol addiction?    Yes    No

If so, who/when: \_\_\_\_\_

Has anyone in your family (including family friends) attempted or completed suicide?    Yes    No

If so, who/when: \_\_\_\_\_

Does your family regularly attend a place of worship?    Yes    No

If Yes, Where: \_\_\_\_\_

How important are spiritual matters to you/your family?    Not at all    Somewhat    Very much

Would you like your spiritual/religious beliefs to be included in your child's counseling?    Yes    No

List any additional members of your household:

Name:                                      Gender:                      Current Age:                      Relationship to Client:

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**PRESENTING ISSUES**

Please tell me why you are seeking counseling for your child: \_\_\_\_\_

\_\_\_\_\_

How long have these concerns been causing you distress? \_\_\_\_\_

Please check the boxes below if you've had concerns with any of the following in your child:

Aggressiveness	Past	Present	Loneliness	Past	Present
Alcohol Abuse	Past	Present	Loss of Control	Past	Present
Anger	Past	Present	Making Decisions	Past	Present
Anxiety	Past	Present	Memory	Past	Present
Apathy	Past	Present	Nervousness	Past	Present
Bad Dreams	Past	Present	Pain	Past	Present
Change in Appetite	Past	Present	Panic	Past	Present
Compulsivity	Past	Present	Physical Abuse	Past	Present
Depression	Past	Present	Racing Thoughts	Past	Present
Difficulty Breathing	Past	Present	Rapid Heart Rate	Past	Present
Digestive Upset	Past	Present	School Performance	Past	Present
Dizziness	Past	Present	Serious Illness	Past	Present
Drug Abuse	Past	Present	Sexual Abuse	Past	Present
Eating Problems	Past	Present	Sexualized Behaviors	Past	Present
Emotional Instability	Past	Present	Sleep Trouble	Past	Present
Fatigue	Past	Present	Social Anxiety	Past	Present
Fears	Past	Present	Stress	Past	Present
Finances	Past	Present	Trauma	Past	Present
Grief/Loss	Past	Present	Trouble Focusing	Past	Present
Guilt	Past	Present	Trouble Relaxing	Past	Present
Headaches	Past	Present	Unhappiness	Past	Present
Hearing Noises/Voices	Past	Present	Unwanted Thoughts	Past	Present
Hopelessness	Past	Present	Verbal Abuse	Past	Present
Impulsive Behavior	Past	Present	Weakness	Past	Present

Is there anything else you want to share about your child or your family? \_\_\_\_\_

\_\_\_\_\_

Who referred you to me? \_\_\_\_\_

May I have your permission to thank this person for the referral? Yes No

**TERMS OF SERVICE**

*I certify that the above information is complete and truthful to the best of my current knowledge and ability. I understand that my child's personal information is kept confidential, unless an exception is made according to the Notice of Privacy Practices, which I have received.*

Parent/Guardian Name (Please Print): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_