Client Name:

CLIENT INFORMATION FORM

Completed by Parent for the Child or Completed by the Child if able

*Please Print Legibly – Information Remains **Strictly** Confidential*

IN ORDER TO FOLLOW UP WITH YOU DURING AND AFTER SERVICES, CHECK EACH APPLICABLE BOX

WORK: Permission to call you_____ #_____

HOME: Permission to call you_____

OTHER: Permission to call you.

Permission to leave message _____

Permission to leave message _____

Permission to leave message_____

MAIL: Permission to use Mailing Address: Y N Special Instructions_____

HOW OR WHO REFERRED YOU?

_____

WHAT CONCERNS BROUGHT YOU TO COUNSELING?

_____

_____

WHAT DO YOU WANT TO SEE HAPPEN AS A RESULT OF COMING HERE?

_____

_____

ANY DETERIORATION IN JOB / SCHOOL PERFORMANCE DUE TO THE PROBLEM?

___Attendance ___Absences Mon/Fri.'s ___Tardiness ___Decrease in productivity
___Erratic Behavior ___Conflict with supervisor ___Discipline ___None
___Promises to Improve ___Accidents/safety violations ___Conflicts with fellow employees

CONSEQUENCES OF DETERIORATING PERFORMANCE ON WORK OR SCHOOL: _____

_____

On a Scale of 1-5, how would your rate your (your child's) distress? (l is low, 5 is severe distress)_____

MEDICAL HISTORY:

Is your child currently under doctor's care? _____ Yes _____ No. Date of last physical exam: _____

Name of your primary care physician: _____

_____Specialist_____

Client Name:

Current health problems (include allergies):

Past Health Problems (include difficulties with developmental milestones under age 18)

Client Name:

Medication currently using: If NONE, write your initials here_____

Medication	Dosage	Doctor Prescribing	Reason Prescribing

Medication Allergies: If **NONE**, initial here_____If yes what:_____

PAST TREATMENT INTERVENTIONS:

Date	Medical & Surgical	Provider/Program/Hospital
Date	**Psychiatric**	**Provider/Program/Hospital**
Date	**Chemical Dependency**	**Provider/Program/Hospital**

Medical Condition Your Child Has: (If yes check)

___Diabetes
___Blood Problems
___Skin/Hair/Nail Problems
___Genital
___Allergies
___Chronic Pain
___ High Blood Pressure
___Bone/Joint Problems
___Liver Disease
___Kidney/Bladder
___Eyes
___Gastrointestinal
___Heart Disease
___Brain Problems
___Respiratory Problems (Breathing)
___Cancer
___Autoimmune
___Head Injury

Sleep Problems:_____

Appetite Problems:_____

Medical Conditions that Run in Your Family: (If yes check)

___Diabetes
___Blood Problems
___Skin/Hair/Nail Problems
___Genital
___Allergies
___Chronic Pain
___ High Blood Pressure
___Bone/Joint Problems
___Liver Disease
___Kidney/Bladder
___Eyes
___Gastrointestinal
___Heart Disease
___Brain Problems
___Respiratory Problems (Breathing)
___Cancer
___Autoimmune

HEALTH HABITS INFORMATION:

For the following questions please base your answers on **the past month** (approximately).

Y N 1. Has your child participated in regular exercise/sports/recreation (about 3 times/week) to keep fit?

Y N 2. Has your child been dieting to lose weight?
Y N 3. Has your child smoked cigarettes?
Y N 4. Has your child experienced any increased feelings of sadness or hopelessness?
Y N 5. Has your child felt more anxious or worried than usual?
Y N 6. In the past **month** has your child used any illicit or non-prescription drugs?
Y N 7. During the past **month** has your child participated in leisure/social/spiritual activities?

MEMBERS OF HOUSEHOLD OR SIGNIFICANT OTHERS WHO LIVE WITH OR ARE DIRECTLY INVOLVED WITH YOUR CHILD

NAME					
AGE					
RELATIONSHIP					
LIVE W/ YOU?					
QUALITY OF RELATIONSHIP Good, Fair, Poor					

SCHOOL HISTORY: (Start with most recent. Grade level and performance. Achievements and problems if any.)

PERSONAL & FAMILY HISTORY: (If present state who, what and when)
Physical
Abuse? _____

_____

Sexual Abuse?_____

_____

Emotional Abuse?
_____

_____

Substance/alcohol abuse?
_____

_____

Client Name:

Suicide?

Mental illness?