If you are uncomfortable answering any questions listed on this form, please leave them blank. If you would prefer, we can discuss these questions in session.

New Client Form – Children

Client's Name: _____ Date of Birth: _____

Client's Address: _____

City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Can I contact the client at home? Y / N Can I leave a voice message? Y / N

Parent(s) Name(s): _____

Parent(s) Contact Number(s): _____

Client lives with: _____

If parents are currently separated or divorced, please describe custody arrangements: _____

_____

What is the client's gender identification? _____

What are the client's gender pronouns? _____

Does the child identify with any culture/ethnicity/religion/spirituality? If so, please list or briefly describe: _____

_____

Emergency Contact Information

Name: _____ Phone Number: _____

Relationship to client: _____

Client's Educational Background

Current grade: _____ School Name: _____

School Address: _____

Current Teacher: _____Current Counselor: _____

IEP/504 Plan: Yes / No If yes, please attach copy of plan to this form.

Special Education Services: Yes / No If yes, please describe: _____

_____

Advanced Placement: Yes / No If yes, please describe: _____

_____

Is the client currently experiencing any problems at school? If so, please briefly describe: _____

_____

_____

May I contact the client's current teacher and/or school staff? Yes / No

Client's Medical History

Is the client currently under the care of a Primary Care Physician? Yes / No

Medical Provider Name: _____

Address: _____

Please list any current or chronic medical conditions: _____

_____

_____

Is the client currently taking any medications? Yes / No

If yes, please list medication and dosage: _____

_____

_____

Any known current drug or alcohol use? If so, please describe: _____

_____

Developmental History

Pregnancy and Delivery:

Please describe any prenatal illnesses, delivery complications, or healthcare concerns:

_____

_____

_____

Early months of life:

Was the child breast-fed? Yes / No If yes, for how long? _____

Any chronic or serious medical concerns or procedures? If yes, please describe: _____

_____

_____

Any sleep issues? If yes, please describe: _____

_____

Was the child delayed in reaching any developmental milestones? If yes, please describe: _____

_____

_____

Any speech, hearing, or language difficulties? If yes, please describe: _____

_____

_____

Has the child ever been placed in any residential, institutional, or foster care programs? If yes, please list the dates, program name, reason for placement, and the outcome: _____

_____

_____

Please describe some of the child's strengths, interests, and talents: _____

_____

_____

Family Information

Is there a parent or guardian that is currently receiving medical care for ongoing health issues? If yes, please describe: _____

_____

_____

Is there a parent or guardian that has previously received care for any serious or chronic health issues? If yes, please describe: _____

_____

_____

Is there a parent or guardian that is currently receiving mental health care? Yes / No

Is there any history of mental health or substance abuse issues in the family? If so, please describe: _____

_____

_____

Has anyone in the family (including family friends) attempted or completed suicide? If yes, please indicate who and when: _____

_____

Do you currently feel that you have a healthy support system? Yes / No

If yes, please describe: _____

_____

Therapy Background

Has the child previously been under the care of a mental health provider, such as a psychiatrist, psychologist, psychotherapist, or counselor? Yes / No

If yes, please briefly describe this experience including the approximate dates of therapy and the nature of the issue(s) for which you sought attention: _____

_____

_____

_____

Has the child experienced any significant life changes in the past year? Yes / No

If yes, please briefly describe: _____

_____

_____

_____

Why are you seeking therapy at this time? _____

_____

_____

_____

How long have these concerns been causing distress? _____

Has the child recently expressed having any suicidal thoughts? Yes / No

Has the child previously had any suicidal thoughts? Yes / No

Has the child ever attempted suicide? Yes / No

What do you hope to gain from therapy at this time? (both for the child and for yourself). _____

_____

_____

_____

Are there currently any resources or social services you need to obtain? If so, please describe: _____

_____

_____

_____

Is there anything else you'd like to note on this form? If so, please use this space:

_____

_____

_____

_____

_____

How were you referred to me? _____