NEW CLIENT INFORMATION SHEET – Child/Adolescent Form

Name:_______________________________ Date of Birth: ___/___/_______ Age ________ Today's Date ________________

MEDICAL

Are you currently under a doctor's care? (check one or more) No psychiatrist family physician other medical doctor

Name of Doctor(s): ____

For what illness(s) are you being treated? ____

Current Medications (prescriptions and over-the-counter): ____

Date of Last Doctor's Visit: ______________ Date of Last Physical Exam: _____________Status of Health: ______________________

Allergies: ____

Indicate recent changes in (check all that apply): weight appetite sleeping patterns mood

Please list any ***major*** illnesses, injuries, health problems you have had: ____________________________________

____

If you have had previous counseling or psychiatric care, please indicate when (approximate) and with whom: ___________________

____

EDUCATION LEVEL: _______________ **SCHOOL CURRENTLY ATTENDING:** ___________________________________

Extracurricular activities: ____

RELIGIOUS AND SPIRITUAL

Do you consider yourself spiritual______? religious_____? Comment? ______________________________________

Do you currently express this spirituality through religious practice? ❑ Yes ❑ No Comment? _____________________

Denominational Preference: _____________________

Current Congregation: ____ How active are you? ❑ None ❑ Some ❑ Very

YOUR INTEREST IN COUNSELING

Please state briefly the reason(s) you have come for counseling: ____

____

____

SELF-DESCRIPTION CHECKLIST: Please check each term below which describes your current feelings.

- ❑ Angry
- ❑ Energetic
- ❑ Ambitious
- ❑ Sad
- ❑ Anxious
- ❑ Isolated
- ❑ Fearful
- ❑ Marital stress
- ❑ Depressed
- ❑ Happy
- ❑ Violent
- ❑ Sleep difficulties
- ❑ Hopeless
- ❑ Confused
- ❑ Dangerous
- ❑ Inadequate
- ❑ Outgoing
- ❑ Lonely
- ❑ Irritable
- ❑ Spiritual worries
- ❑ Bereaved
- ❑ Guilty
- ❑ Ashamed
- ❑ Cheerful
- ❑ Fatigued
- ❑ Suicidal
- ❑ Unhappy
- ❑ Optimistic
- ❑ Distrustful
- ❑ Apathetic
- ❑ Hurt
- ❑ Numb
- ❑ Abused
- ❑ Loss of appetite
- ❑ Worried
- ❑ Panic
- ❑ Puzzling ideas
- ❑ Resentful
- ❑ Hopeful
- ❑ Jealous
- ❑ Indifferent
- ❑ Work stress
- ❑ Poor sex drive
- ❑ Loss of faith/God
- ❑ Loss of faith/Self
- ❑ Loss of faith/Other
- ❑ Loss of meaning
- ❑ Loss of self respect
- ❑ Loss of love
- ❑ Loss of control
- ❑ Overeating
- ❑ Drug use
- ❑ Alcohol use
- ❑ Fretful
- ❑ Unwelcome thoughts

YOUR FAMILY

Person's Name	Age or Year If Deceased	Marital Status	Education	Occupation	Quality of Your Relationship	Mental/Physical Illness
Mother:						
Father:						
Step-Mother:						
Step-Father:						
Other Primary Care Giver(s):						
Siblings:						