FAMILY/CHILD/ADOLESCENT PERSONAL DATA

Date:_____ Referred By:_____

MINOR CLIENT INFORMATION: Name _____ Male □ Female □

Address:_____ City:_____ Zip Code:_____

Home Phone (___)_____ Parent's Cell (___)_____ Minor's Cell (___)_____

Age:_____ Birthdate:_____ School Grade:_____ Email: _____

Ethnicity: Caucasian □ African American □ Hispanic □ Asian □ Other □ :_____

Would minor like spirituality/religious issues to be a part of your therapy? Y / N / Don't Know

NOTE: It is important for the client & therapist to determine together what part spiritual/religious issues will/will not take in therapy.

CUSTODY INFORMATION: *"Prior to the commencement of counseling services to a minor client who is named in a custody agreement or court order, a licensee shall obtain and review a current copy of the custody agreement or court order, as well as any applicable divorce decree. A licensee shall maintain these documents in the client's record."*

Quoted from the Texas State Board of Examiners of Licensed Professional Counselors 681.41,z (aa)

Biological parents: Date of marriage (if applicable): _____ Date of divorce (if applicable): _____

If divorced, a full copy of divorce decree must be provided prior to services being rendered.

Who has the *legal access* to this minor's confidential mental health record? (please check all that apply)

Bio father ___ Bio mother ___ Step-mother ___ Step-father ___ Guardian ___

Bio father's name_____ Ph. # _____ Email:_____

Bio mother's name_____ Ph. # _____ Email:_____

Step-father's name_____ Ph. # _____ Email:_____

Step-mother's name_____ Ph. # _____ Email:_____

Guardian's name_____ Ph. # _____ Email:_____

IN CASE OF EMERGENCY: Person to notify :_____ Ph #:_____

PARENTS AND NON-EMANCIPATED MINOR CLIENTS 12 years of age or older can consent to psychological services subject to the involvement of their parents or guardian:

- Unless the therapist determines that parental involvement would be detrimental.
- A client over 12 years of age may independently consent to psychological services if he or she is mature enough to participate intelligently in such services, and/or the minor client either would present a danger of serious physical or mental harm to him or herself or others, or is the alleged victim of incest or child abuse.
- Clients over 12 years old may independently consent to alcohol/drug treatment in some circumstances.
- Non-emancipated patients under 18 years of age and their parents should be aware that the law may allow parents to examine their child's treatment records unless the therapist determines that access would have a detrimental effect on the professional relationship with the client, or to his/her physical safety or psychological well-being.
- It is our policy to request an agreement between minors (over 12 years of age) and their parents about access to information. This agreement provides that during treatment, the therapist will provide parents with only general information about the progress of the treatment, and the client's attendance at scheduled sessions. Therapists will encourage parent participation when appropriate.

If I request a signed note from my child's therapist in order for my child to attend therapy during school hours, and then present that signed note to my child's school in order for my child to not accrue an unexcused absence, I am concurrently Releasing this therapist from any liability re: Confidentiality.

Is this minor child party to parents' divorce proceedings? Y / N If so, by signing below you are commiting to offer the most recent temporary orders or divorce decree.

I agree to be responsible for the payment of $_____per session which is payable at the time of the session. A $35 fee will be charged on all returned checks.

Parent/Guardian Signature_____ Date_____ Therapist Initials_____

Minor: In your own words, please state the nature of the main problem:

Parent: In your own words, please state the nature of the main problem:

How would you rate how serious this problem feels to you? (Circle one) 1 2 3 4 5
Mildly Upsetting Extremely Serious

What would you like to accomplish through counseling?

FAMILY STATUS

Parents: Father: Age_____ Occupation_____ Date of Birth: _____
Mother: Age_____ Occupation_____ Date of Birth: _____
Marital Status of Parents: □ Single □ Married □ Divorce □ Separated □ Living Together □ Other
Custody Arrangement: _____
o Step-father: Age_____ Step-mother: Age_____
If divorced, please specify minor's age at divorce and circumstances surrounding divorce: _____
_____
Briefly describe minor's relationship with minor's Father: _____
With minor's Mother: _____
Siblings: Brothers' first names: _____ Date(s) of Birth: _____
Sisters' first names: _____ Date(s) of Birth: _____
Other: Please explain if any member of the family has ever suffered from anything that could be described as an "emotional" or "psychological" problem: _____
_____
Please mention any history of domestic violence, child abuse or sexual abuse in the family: _____
_____
Please comment on any history of alcohol or drug use in the family: _____
_____

MINOR'S DEVELOPMENTAL HISTORY (If yes, please describe)

Pregnancy Planned: □ Yes □ No Parents' Attitudes Toward Having Children: _____
_____
Complications with Pregnancy: □ Yes □ No _____
Premature Birth: □ Yes □ No _____
Age When: Crawled: _____ Walked: _____ Spoke First Word: _____ Spoke First Sentence: _____
Developmental Delays □ Yes □ No _____

MINOR'S CURRENT FUNCTIONING (If yes, please describe)

Behavioral Problems: ☐ Yes ☐ No _____
Problems with Parents: ☐ Yes ☐ No _____
Problems with Siblings: ☐ Yes ☐ No _____
Problems with Peer Relationships: ☐ Yes ☐ No _____
Substance Abuse: ☐ Yes- ☐ No _____
Sexually Active: ☐ Yes ☐ No _____
Any Cultural Considerations? ☐ Yes ☐ No _____

MINOR'S MEDICAL HISTORY

Current Weight: _____ One Year Ago: _____ Maximum: _____ When: _____
Does minor exercise regularly? ☐ Yes ☐ No How? _____
Does minor sleep well? ☐ Yes ☐ No Amount (hours): _____ Easy to get to sleep? ☐ Yes ☐ No
What recreation does minor enjoy? _____
Physician: _____ City: _____ Date of last physical: _____
The hardest time in minor's development was: ☐ Preschool ☐ Grade School ☐ Jr. High ☐ High School

MINOR'S MEDICAL CONDITIONS

Please check all that apply to you:

	NEVER	SELDOM	SOMETIMES	OFTEN
Insomnia	☐	☐	☐	☐
Loss of Appetite	☐	☐	☐	☐
Back Pain	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Headaches	☐	☐	☐	☐
Phobias (Fears)	☐	☐	☐	☐
Nausea	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Nervousness	☐	☐	☐	☐
Loss of temper	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐
Depression	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Constipation	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐
Over-eating	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐

OTHER CONCERNS

Smoking ☐ ☐ ☐ ☐
- Packs per week_____

Alcohol Intake: ☐ ☐ ☐ ☐
- Frequency (per week): _____
- How Much? _____
- What do you drink? _____

Marijuana ☐ ☐ ☐ ☐
- Amount per week: _____

Drugs (not medications) ☐ ☐ ☐ ☐
- What? _____
- Frequency: _____

MINOR'S MEDICATION HISTORY

Please check all that apply to you:

	NEVER	SELDOM	SOMETIMES	OFTEN
Appetite Suppressants	☐	☐	☐	☐
Pain Relievers	☐	☐	☐	☐
Sedatives/Tranquilizera	☐	☐	☐	☐
Sleep Aids	☐	☐	☐	☐
Stimulants	☐	☐	☐	☐
Blood Pressure Meds	☐	☐	☐	☐
Heart Medicine	☐	☐	☐	☐
Vitamins	☐	☐	☐	☐
Other (please specify)	☐	☐	☐	☐

Please list all current medications:

Medication	Dosage	Reason

Comments:

MINOR'S EDUCATIONAL HISTORY (If yes, please describe)

School: _____ Grade: _____

Type of Class: □ Regular □ Gifted □ Other _____

School Problems: □ None _____

Skipped a grade: □ Yes □ No _____

Held back a grade: □ Yes □ No _____

MINOR'S TREATMENT/THERAPY HISTORY

Has minor ever had any previous counseling or psychotherapy? □ Y □ N

If YES, please list from most recent:

Problem	Dates	Therapist/Location	Was Therapy Successful?

Has minor ever attempted suicide? □ Y □ N If YES, when? _____

If YES, method used: _____

Has minor ever been hospitalized for psychiatric reasons? □ Y □ N

- If YES, when? _____ Length of hospital stay: _____

ADDITIONAL INFORMATION

What are minor's strengths/talents? _____

_____

_____

_____

_____

_____

_____

Additional comments:

_____

_____

_____

_____

_____

_____

_____

Following information for parent primarily responsible for payment:

Name: _____

Occupation: _____ Employer: _____

Employer's Address: _____ Phone: _____