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Client Information Form (Minor)

Client (minor) please complete this form (with parent/guardian assistance if needed) and we will review this information together.

Name: _____ **Date:** _____

What made you decide to seek counseling now? _____

_____

_____

What are your expectations of counseling? _____

_____

_____

Describe any prior counseling experiences _____

_____

_____

Prior treatment experiences:

	With Whom/Where?
Counseling/Psychiatric treatment	
Drug/alcohol treatment	
Self-help groups (AA,EDA, Al-Anon, etc.)	

Currently experiencing (check all that apply)

Emotional Difficulties
- ☐ Anger
- ☐ Anxiety
- ☐ Depression
- ☐ Fear
- ☐ Grief
- ☐ Guilt
- ☐ Loneliness
- ☐ Mania

Relationship Difficulties
- ☐ Boss/Coworker
- ☐ Boyfriend/Girlfriend
- ☐ Friends
- ☐ Parent/Child
- ☐ Sibling
- ☐ Teacher/Coach
- ☐ Other: _____
- _____

Compulsive/Addictive Difficulties
- ☐ Alcohol
- ☐ Food
- ☐ Gaming/Internet/TV
- ☐ Illegal Drugs
- ☐ OTC/Prescription Drugs
- ☐ Relationships/Co-dependent
- ☐ Sex
- ☐ Shopping/Gambling/Spending

Recent changes? (check all that apply)

☐ Sleeping Patterns ☐ Eating Patterns ☐ Energy Level
☐ Physical Activity ☐ Weight ☐ General Mood/Disposition
☐ Moved ☐ New/Lost Job ☐ Other: _____
☐ Increased Tension ☐ New School _____

If yes to any of the above, please describe _____

_____

_____

Family and Relationship Information

Who do you live with? _____

Relationship	Name	Living with You?		Current Age (or deceased date)
		Y	N	
Mother				
Father				
Siblings				
Significant Others (grandparents, step-relatives, half-relatives) *Please specify relationship*				

Where were you born? _____

Where did you grow up? _____

Who raised you? _____

Parent Information ☐ Parents Legally Married ☐ Parents Separated ☐ Parents Divorced
☐ Mother Remarried (number of times: ___) ☐ Father Remarried (number of times: ___)
☐ Other: _____

Describe your relationship with your mother: _____

_____

Describe your relationship with your father: _____

_____

Describe your relationship with your sibling(s): _____

_____

Sexual Information

What is your sexual preference? ☐ Male ☐ Female ☐ Both ☐ Uncertain

Are there sexual issues you would like to discuss? □ Yes □ No

<u>Painful Life Experiences</u>

Have you ever been abused (emotionally, physically, sexually, verbally)?

Who/What?	When?

Have you experienced any significant losses (deaths, moves, financial, etc.)?

Who/What?	When?

Have you experienced any trauma (witnessed or experienced violence, accident, war, criminal act, etc.)?

Who/What?	When?

Interests and Hobbies

☐ Art ☐ Outdoor Activities ☐ Books

☐ Diet/Health ☐ Films ☐ Cooking

☐ Music ☐ Physical Fitness ☐ Other: _____

☐ Crafts ☐ Sports _____

Do you participate in any activities/clubs/organizations? _____

_____

Religious and Spiritual Information

Do you believe in a god or power greater than yourself? ☐ Yes ☐ No

What was your religious or spiritual upbringing? _____

What is your current religious or spiritual practice? _____

How often do you engage in this religious or spiritual practice? _____

How important is this religious or spiritual practice to you? _____

Education

☐ Did not complete high school (Last grade completed? _____)

☐ Currently enrolled in high school (Grade? _____)

☐ High School diploma/GED

☐ Currently enrolled in college/vocational training (Year/Specialty? _____)

Learning Differences

☐ Gifted ☐ ADHD ☐ Dyslexia ☐ Processing ☐ Other: _____

Employment

Briefly describe your employment history, beginning with your most recent job/internship.

Employer	Dates	Job Description

Nutritional Information

Are you contented with your nutritional intake? Concerned? _____

_____

Do you have an illness/condition that impacts your eating (diabetes, allergies, etc.)? _____

_____

How often do you eat every day (meals and snacks)? _____

How much protein do you eat daily? Vegetarian? _____

How many fruits and vegetables do you eat daily? _____

How many starches do you eat daily? Simple? Complex? _____

How many fats do you eat daily? Saturated? Unsaturated? _____

How many sweets/desserts do you eat daily? _____

How many dairy products do you eat daily? _____

Have you lost or gained more than 10 lbs. in the last six months? ☐ Yes ☐ No _____

Are you concerned that you might have some eating disorder symptoms? ☐ Yes ☐ No
If yes, please complete the Eating Disorder Questionnaire.

Legal Information

Are you presently on probation or parole? If yes, please explain. ☐ Yes ☐ No _____

_____

Are you currently involved in any active legal traffic/civil/criminal cases? If yes, explain. ☐ Yes ☐ No

_____

Please describe any past convictions (age/sentence/traffic, civil or criminal) _____

_____

Alcohol and Other Drug Use Information

Drug Type	When First Used	When Last Used	Frequency	Problem for You?
DEPRESSANTS				
Alcohol (beer, wine, liquor)				□ Yes □ No
Anti-Anxiety (Valium, Librium, Tranxene, Xanax, Ativan, Serax, etc.)				□ Yes □ No
NARCOTICS				
Heroin, Opium, Morphine, Codeine, Tylenol #3/#4, Methadone, Dilaudid				□ Yes □ No
STIMULANTS				
Amphetamines (Benzedrine, Dexadrine, Ritalin, etc.)				□ Yes □ No
Cocaine/Crack				□ Yes □ No
Caffeine				□ Yes □ No
Nicotine				□ Yes □ No
CANNABIS				
Marijuana, Hashish				□ Yes □ No
HALLUCINOGENS				
LSD, PCP, MDMA, DXM				□ Yes □ No
OTHER				
				□ Yes □ No

Have you ever had any legal problems related to your use of alcohol/drugs? ☐ Yes ☐ No

Have you ever had any relationship problems related to your use of alcohol/drugs? ☐ Yes ☐ No

Family Alcohol and Other Drug Information

Please describe the alcohol/drug problems of others in your family, past and present.

Who/Relationship	Problem Type	Treatment Recovery

Impacts of Alcohol and Other Drugs

Please check all that apply.

Physical

□ Blackouts
□ Memory Problems
□ Tremors / Shakes
□ Seizures
□ Delirium Tremens (DT's)
□ Hallucinations
□ Overdose
□ Appetite Problems
□ Nausea/Vomiting
□ Sleep Problems
□ Sexual Problems
□ Injury
□ Accidents
□ Liver Damage
☐ Other _____
_____

Emotional

□ Depression
□ Confusion
□ Concentration Problems
□ Anxiety
□ Irritability/Restlessness
□ Aggressiveness
□ Mood Swings
□ Impulsivity
□ Euphoria
□ Relaxation
□ Extreme Jealousy
□ Paranoia
□ Feelings of Guilt/Shame
□ Suicidal Thoughts
□ Homicidal Thoughts
☐ Other _____
_____

Behavioral

□ Morning Use
□ Sneaking
□ Gulping
□ Loss of Control
□ Using for Relief
□ Impulsive Use
□ Use Despite Negative Consequences
□ Associate with Friends That Use
□ Plan Activities Around Use
□ Loss of Interest in Activities
□ Change in Work/School Performance
□ Work/School Lateness/Absenteeism
□ Job Loss Due to Use
□ Frequent Arguments
□ Financial Problems
□ Legal Problems
□ Physically Abusive to Self
□ Physically Abusive to Others
□ Suicide Attempts
□ Homicide Attempts
☐ Other _____
_____

Medical Information

Primary Care Physician _____ **Phone** _____

	Date	Reason	Results
Last physical check-up			
Last Doctor's visit			
Last Dental visit			

Please check any of the following medical problems you have had:

☐ Adrenal problems ☐ Head Injury/Loss of Consciousness ☐ Anemia ☐ Brain Tumor ☐ Diabetes

☐ Kidney/Bladder problems ☐ Liver problems ☐ Cancer ☐ Thyroid problems ☐ High Blood Pressure

☐ Lung problems ☐ Glaucoma ☐ Seizures/Epilepsy ☐ Stroke ☐ Heart problems ☐ Asthma

☐ Meningitis or Encephalitis ☐ Sexually transmitted disease ☐ Allergies

If yes to any of the above, please describe and give dates: _____

_____

_____

Current Medical Problems

Please check all that pertain to you now:

Eyes:	□ Double Vision □ Eye Pain □ Problems with Vision
Ears:	□ Hearing Aid □ Buzzing/Ringing □ Infection □ Problems with balancing □ Hearing problems
Nose:	□ Nose bleeds □ Stuffy nose
Mouth:	□ Loss of taste □ Problems with teeth □ Dentures
Respiratory:	□ Shortness of breath □ Chronic cough □ Mucus production □ Positive TB test □ Coughing up blood
Skin/Joint/Muscle:	□ Changes in skin □ Changes in nails □ Changes in hair □ Skin rash □ Itchy/Dry skin □ Cramps in legs/arms □ Stiff/swollen joints □ Difficulty walking
Gastrointestinal:	□ Difficulty swallowing □ Heartburn □ Nausea □ Vomiting □ Diarrhea □ Constipation □ Blood in stool □ Black tarry stool □ Abdominal pain
Genito/Urinary:	□ Pain/burning with urination □ Frequent urination at night □ Bloody/brown urine □ Difficulty starting urine flow □ Constant need to urinate
Nervous System:	□ Headaches □ Numbness □ Fainting spells □ Convulsions/seizures □ Memory problems □ Coordination problems □ Tremors/shakes □ Loss of movement □ Loss of sensation
General Health:	□ Overweight □ Underweight □ Chills □ Fever □ Tire easily □ Night/day sweats □ Chronic pain
Cardiovascular:	□ High blood pressure □ Low blood pressure □ Heart skips a beat □ Palpitations □ Fast heart rate □ Chest pains □ Swollen ankles
Females Only:	□ Menstrual irregularities □ Menopause □ Problem pregnancy □ Miscarriage #: □ Abortion #: □ Premenstrual problems □ Infertility □ Currently pregnant

If you checked any of the above, please describe: _____

_____

_____

Any medication allergies? If yes, please describe. ☐ Yes ☐ No _____

Counseling and psychotherapy can be most helpful when every aspect of you and your life is taken into consideration. Please reflect on the emotional, psychological, behavioral, physical, social, occupational and spiritual aspects of yourself.

At this point in your life, what is most important to you? _____

Is there anything else you would like to tell me about yourself? _____