YOUTH CLIENT INFORMATION SHEET FOR GAURDIAN

Please note: information you provide here is protected as confidential information.

Child's Name: _____ Birth date: ___/___/____ Gender: ____

LEGAL GUARDIAN DEMOGRAPHIC/CONTACT INFO

If applicable, please check if there are custody arrangements for your child: □ YES □ NO

*I will need a copy of legal documentation/parenting plans prior to starting treatment.

Guardian 1: Relation to patient: _____

Full Name: _____ Birth date: ___/___/____ Gender: _____

Address: _____

Home Phone: _____ Cell/Other Phone: _____

E-mail: _____

*Please note: Email correspondence is not considered to be a confidential medium of communication.

May I email you? □Yes □No May I leave a voicemail on these numbers? □Yes □No

If different from above, please indicate the address and telephone number you want me to use to contact you:

_____

Guardian 2: Relation to patient: _____

Full Name: _____ Birth date: ___/___/____ Gender: _____

Address: _____

Home Phone: _____ May I leave a message? □ YES □ NO

Cell/Other Phone: _____ May I leave a message? □ YES □ NO

E-mail: _____ May I email you? □Yes □No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

If different from above, please indicate the address and telephone number you want me to use to contact you:

_____

EMERGENCY CONTACT

Who shall I contact in case of emergency? Name:_____

Phone (_____)_____ Relationship to your child:_____

MEDICAL AND HEALTH HISTORY OF YOUR CHILD

Primary Care Physician: _____ Phone: _____

Psychiatrist: _____ Phone:_____

Other Medical Providers: _____ Phone: _____

1. Please list all chronic medical conditions OR any serious medical operations?

_____

2. Does your child currently have any physical or learning disabilities? □ No □ Yes

3. If your child currently taking any prescription medication? □ No □ Yes

If yes, please list all current medications, doses, and what your child takes the medication for:

_____

4. Has your child previously received any type of mental health services? □ No □ Yes
Has your child ever been hospitalized for mental health reasons? □ No □ Yes

If yes, list all therapists and psychiatrists your child has seen in the past and when your child

saw them: _____

_____

5. Has your child ever had substance abuse treatment? □ No □ Yes

Please explain if you suspect or your child is currently using any substances that are not prescribed? _____

Check if there is a family history of any of any of the following mental health concerns:
☐ Alcohol/Substance Abuse ☐ Anxiety ☐ Bipolar Disorder ☐ Depression ☐ Domestic Violence ☐ Eating Disorders

☐ Obsessive Compulsive Behavior ☐ Phobias/Panic ☐ Schizophrenia ☐ Suicide Attempts ☐ ADHD

☐ Other:_____

EDUCATION

School: _____ Grade: _____

Teacher/Primary contact(s):_____

Academic Performance: _____

Social Concerns/Strengths: _____

Academic Concerns/Special Accommodations: _____

PSYCHOSOCIAL INFORMATION

1. Do you suspect or has your child ever experienced/witnessed any form of…

Physical Abuse? □ No □ Yes **Sexual Abuse?** □ No □ Yes

Verbal/Emotional Abuse? □ No □ Yes **Domestic Violence?** □ No □ Yes

2. Do you suspect or has your child ever had thoughts of…

Harming him/herself? □ No □ Yes **Harming others?** □ No □ Yes

If yes to the above, please explain if your child has ever acted on these thoughts? _____

_____

3. Please list any significant life changes, stressful events, or losses your child has experienced recently: _____

_____

4. What bring(s) you to seek counseling at this time? What would you like to accomplish out of your time in therapy? _____

_____

_____

_____

Print Legal Guardian's Name Signature Date

_____

Print Legal Guardian's Name Signature Date