

NEW CLIENT INFORMATION-MINOR

Client Information

Date: _____ **Name:** _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (City) (State) (Zip)

Date of Birth: _____ **Gender:** Male [] Female [] **Last 4 of Social:** _____ **Age:** _____

School/District: _____ **Grade:** _____ **Ethnicity/Race:** _____

Parent/Guardian Name: _____ **Phone:** _____

Email: _____ **Relationship to Minor:** _____

Home: _____ **Work:** _____ **Preferred Method of Contact:** _____

May we leave confidential messages? Yes [] No [] **Who does the minor live with?** _____

Referred By: _____ **Phone:** _____

Emergency Contact

Name: _____ **Phone:** _____

Relationship to Client: _____

Family History

Mark all that apply for your family history:

- | | | |
|--|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Anxiety Disorders |
| <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Trauma History |
| <input type="checkbox"/> Homicide | <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Suicide Attempts |

Additional Information

Is the minor being required to attend therapy due to a court order? _____

Were you advised to seek treatment for the minor by a doctor or school official? _____

~Progressing on Purpose Counseling, PLLC~

8300 Cypress Creek Parkway Ste 472 * Houston, Texas 77070

Office: 281-671-6804 * Business Cell: 713-302-1030 * Fax: 281-671-6601

Symptom Assessment

Mark all the symptoms that the minor is experiencing:

- | | | |
|--|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Extreme Sadness | <input type="checkbox"/> Trouble Concentrating |
| <input type="checkbox"/> Change in eating habits | <input type="checkbox"/> Poor job performance | <input type="checkbox"/> Self-esteem issues |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Anger issues | <input type="checkbox"/> Self-harm |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Unable to sleep |
| <input type="checkbox"/> Isolation/withdrawal | <input type="checkbox"/> Physical pain | <input type="checkbox"/> Weight changes |
| <input type="checkbox"/> Feelings of panic | <input type="checkbox"/> Feelings of guilt | <input type="checkbox"/> Substance use |
| <input type="checkbox"/> Feeling lonely | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Acts of violence | <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Suicide Attempts |

Health and Social History

Primary Care Physician: _____ Phone: _____

Has the minor ever been diagnosed with a mental disorder? Yes No Diagnoses: _____

By Whom? _____

Current Medications:

Medication	Dosage/Frequency	Effective Date	Purpose

Has the minor ever been hospitalized for psychological reasons? Yes No

Hospital	Month/Year	Reasons

Have they contemplated suicide? Yes No When? _____

Have they contemplated homicide? Yes No When? _____ Who? _____

Have they received previous counseling or psychotherapy? Yes No

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Health and Social History Continued

If so, by whom: _____ When? _____

How long? _____ Phone: _____

Please rate the following (1= poor; 5= excellent)

Work _____ Family _____ Peer Relationships _____ School _____ Overall Happiness _____

In the past week, has the minor experienced (Mark all that apply):

Anger Fear High Energy Sadness Tension Concerns about body

Added Information

Please complete the following statements:

The goal for my minor... _____

Areas of concern... _____

Strengths of the minor... _____

Information You Want The Therapist To Know

I testify that to the best of my knowledge the information that I have provided is accurate and true. I understand that falsifying information is unlawful and punishable. I understand that the therapist may share my minor's information with other professionals with the intent to consult for treatment purposes. I also understand that this information will be safeguarded for legal and confidentiality reasons. I have been able to ask all clarifying questions to ensure my understanding going forward.

Parent/Guardian(s) Name (Please Print) Parent/Guardian(s) Signature Date

By checking this box, you acknowledge and accept the signature above as your own.