~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

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:

☐ **Depression**	☐ **Bipolar Disorder**	☐ **Anxiety Disorders**
☐ **Panic Attacks**	☐ **Schizophrenia**	☐ **Substance Abuse**
☐ **Eating Disorder**	☐ **Learning Disabilities**	☐ **Trauma History**
☐ **Homicide**	☐ **Hospitalization**	☐ **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? _____

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Symptom Assessment

Mark all the symptoms that the minor is experiencing:

☐ **Depression**	☐ **Extreme Sadness**	☐ **Trouble Concentrating**
☐ **Change in eating habits**	☐ **Poor job performance**	☐ **Self-esteem issues**
☐ **Hopelessness**	☐ **Anger issues**	☐ **Self-harm**
☐ **Stress**	☐ **Nightmares**	☐ **Unable to sleep**
☐ **Isolation/withdrawal**	☐ **Physical pain**	☐ **Weight changes**
☐ **Feelings of panic**	☐ **Feelings of guilt**	☐ **Substance use**
☐ **Feeling lonely**	☐ **Memory loss**	☐ **Trauma**
☐ **Acts of violence**	☐ **Lack of energy**	☐ **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.**