Demographic Information

Client Name: _____ Date: _____

DOB: _____ Age: _____ Gender: _____

Birthplace: _____

Parent/guardian name(s): _____

Address(es): _____

Email address(es): _____

Phone Number(s): _____

Is it ok to leave a voicemail?	*YES*	*NO*
Is it ok to text appointment reminders?	*YES*	*NO*
Is it ok to email treatment-related messages?	*YES*	*NO*
Is it ok to send you something in the mail?	*YES*	*NO*

How Have We Come to Meet?

What are the 3 biggest concerns you have for your child right now? How long have each been going one? Put them in order of importance:

1. _____
2. _____
3. _____

What do you think your child would say their biggest concern(s) is/are?

_____
_____
_____

What solutions (helpful or unhelpful) have you tried to resolve the above concerns?

_____
_____
_____

Have you or your child(ren) had therapy in the past? If so, please provide treatment providers names, dates of service, what your child was seen for, and results.

_____
_____
_____
_____

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Change is Coming…

What are your expectations from therapy and the therapist?

_____

_____

If you had a crystal ball and were able to look into the future, you will say therapy has been worth it because… (list concrete changes you would like to see):

_____

_____

_____

What other things would you like to see change in your life and your family's life?

_____

_____

Do you foresee any obstacles to achieving your goals/changes?

_____

_____

How long do you think therapy will need to last to achieve the changes/goals you want?

_____

List 5 strengths about your child, give examples of each:

1. _____
2. _____
3. _____
4. _____
5. _____

Medical Background

Has your child ever received psychiatric services before? YES NO
If yes, how long ago, with whom, for what, and results:

_____

_____

Does your child have any allergies? _____

Any current or past medical issues, hospitalizations, accidents, injuries or surgeries? If yes, for what?

_____

_____

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Is your child presently under a physician's care? If so, for what?

_____

_____

List medications (over the counter & prescribed), supplements, alternative treatments (acupuncture, chiropractic, etc.) your child is taking/doing and reasons:

_____

_____

Tell us about the pregnancy of your child (full term, preemie, any complications during pregnancy or at birth, environment and situations during pregnancy and birth).

_____

_____

Tell us about your child's development milestones (delayed, on time, early)

_____

_____

Important Questions We Must Ask

Has your child ever had suicidal ideations? YES NO
If yes, please explain:

_____

_____

Has your child ever planned to hurt himself/herself? YES NO
If yes, please explain:

_____

_____

Has your child ever attempted to hurt himself/herself? YES NO
If yes, please explain:

_____

_____

Has your child ever felt like he/she wanted to seriously hurt or harm someone else?
If yes, please explain: YES NO

_____

_____

Do you have weapons in your home or access to weapons? YES NO
If yes, who has access to them and what are the safety protocols around them?

_____

_____

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Is there any history past or present of abuse or violence? YES NO
If so, please explain:

_____
_____

Is your child currently using any illegal drugs or is the reason you are seeking therapy services substance related?

_____
_____

Has your child ever witnessed or experienced a trauma? Does your child have recurring nightmares, flashbacks, or avoids anything that is uncomfortable or painful? Please explain:

_____
_____

Are you concerned your child may see or hear things that don't appear to be real? If so, please explain:

_____
_____

Has your child even been arrested, been involved with the juvenile justice system, or is engaging in behaviors that put him/her at risk? If so, please explain?

_____
_____

Do you or your child have questions or concerns about their sexuality, gender or sexual development?

_____
_____

Education, Responsibility, Recreation and Leisure

What school does your child attend? _____

What grade is your child in? _____

How are your child's grades? _____

Has your child ever been held back or receive specialized academic services? If so, for what?

_____

What concerns if any do you have about your child's education or schooling (grades, peers, relationships with teachers, etc)?

_____
_____

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What would your child say he/she likes and dislikes about school:
Likes: _____
Dislikes: _____

What responsibilities does your child have at home?

_____
_____

If your child is age 15 or above, what other skills do you think they need to be independent? How is he/she learning them? What else does he/she need to gain independence?

_____
_____

What other responsibilities or skills would you like to see your child have/achieve?

_____
_____

Does your child have his/her own cell phone? YES NO

If so, what are the rules around your child's cell phone use? Who enforces those rules?

_____

Does your child have his/her own computer, gaming system, or tablet? YES NO

If so, what are the rules around use? Who enforces those rules?

_____

Understanding Your Family

* *Space left for therapist to draw family tree (genogram)*

Parent's marital status:

Married Divorced Never Married Separated Domestic Partners Widowed

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If 1 or both parents are absent, for how long and reason for absences:

_____

_____

If parents are not together please describe the parents' relationship with one another:

_____

_____

Who lives in the home(s) with the child?

_____

_____

List 5 or more strengths of your family:

_____

_____

Is there anything that gets in the way of your family being the way you want it to be?

_____

_____

Describe your child's relationship with the following:
Mother: _____
Father: _____
Siblings: Age, Name and Sex:

a. Sibling 1 _____
b. Sibling 2 _____
c. Sibling 3 _____
d. Sibling 4 _____

Significant Other(s): _____
Other(s): _____

Does your family belong to any religious or spiritual groups? YES NO
If yes, what is it and what is your level of involvement?

_____

Who else do you consider to be part of or supportive to your family (people or affiliations):

_____

How do you envision your involvement in your child's therapy?

_____

Is there anything else that you think is important for us to know about your child?

_____

_____

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