Client Registration

FULL NAME _____ TODAY'S DATE _____

FIRST MI LAST

PREFERRED NAME: _____ DOB/AGE_____

Child lives with: □ Both Parents □ Mother □ Father □ Other: _____
If separated, who has custody? _____ Please provide documentation from the courts to your appointment

DEMOGRAPHICS

SS#/SIN _____ GENDER □Male □ Female □ Other:_____

_____

STREET/APT CITY STATE ZIP CODE

Primary No. (_____)-_____-_____ (Message Ok □ Yes □ No) Prefer: □ Voice □Text □ Both
Email: _____ (Email Ok □ Yes □ No)
*Please note: Email correspondence is not considered to be a confidential medium of communication

How did you learn about us? Online/list site, referral/who, signage, other?_____

REASON FOR THERAPY

Briefly describe your reason for seeking counseling services: _____
_____
_____

What do you hope your child gains from therapy: _____
_____
_____

PARENTS INFORMATION

MOTHER'S DEMOGRAPHICS

FULL NAME _____ DOB/AGE_____

FIRST MI LAST

PREFERRED NAME: _____

_____

STREET/APT CITY STATE ZIP CODE

Primary No. (_____)-_____-_____ (Message Ok □ Yes □ No) Prefer: □ Voice □Text □ Both

Employer: _____ Work Phone: _____(Message Ok □ Yes □ No)
Email: _____ (Email Ok □ Yes □ No)
*Please note: Email correspondence is not considered to be a confidential medium of communication

List the people who live in your mother's home:

NAME	AGE	RELATIONSHIP		NAME	AGE	RELATIONSHIP

FATHER'S DEMOGRAPHICS
FULL NAME _____ DOB/AGE_____
FIRST MI LAST
PREFERRED NAME: _____
_____
STREET/APT CITY STATE ZIP CODE

Primary No. (_____)-_____-_____ (Message Ok □ Yes □ No) Prefer: □ Voice □Text □ Both
Employer: _____ Work Phone: _____(Message Ok □ Yes □ No)
Email: _____ (Email Ok □ Yes □ No)
*Please note: Email correspondence is not considered to be a confidential medium of communication

List the people who live in your father's home:

NAME	AGE	RELATIONSHIP		NAME	AGE	RELATIONSHIP

GENERAL & MENTAL HEALTH

MENTAL HEALTH
Please check any and ALL of the following areas in which your child is experiencing problems:

□ Nervousness	□ Depression	□ Shyness	□ Sexual Problems
□ Suicidal Thoughts	□ Separation/Divorce	□ History of abuse/trauma	□ Finances
□ Frequent Drug Use	□ Frequent Alcohol Use	□ Friends	□ Anger
□ Sleep	□ Self-Control	□ Gambling	□ Unhappiness
□ Stress	□ Feeling fearful/anxious	□ Relaxation	□ Headaches
□ Tiredness	□ Legal Matters	□ Memory	□ Grief/Loss
□ Energy	□ Making Decisions	□ Spiritual Concerns	□ Loneliness
□ Inferiority Feelings	□ Concentration	□ Career Choices	□ Health Problems
□ Nightmares	□ Marriage	□ Children/Parenting	□ Work
□ Stomach Discomfort	□ Obsessions/Compulsions	□ Self Harm	□ Appetite

How long has your child had the symptoms listed above? _____

How distressing are the symptoms for your child: □ 1 (low) □ 2 □ 3 □ 4 □ 5 (severe)

Any deterioration due to symptoms above: □ Work/School □ Relationships □ Erratic behavior/emotions
Please explain:
_____
_____
_____

How would you describe your child's approach to new situations?
□ Jumps Right In □ Cautious, slow to warm □ Withdrawn, tends not to participate

How would you describe your child's overall mood? □ Positive (Happy, laughing, upbeat & hopeful)
□ Negative (Angry, hostile, depressed & cranky) □ Mixed (more positive) □ Mixed (more negative)

Is your child seeing any other therapist? □ NO □ YES If yes, who? _____ #_____
Does your child have a psychiatrist? □ NO □ YES If yes, who? _____ #_____

Has your child EVER received psychiatric help, psychiatric hospitalization, detox, substance abuse treatment or any counseling. _____
_____
_____
_____

GENERAL HEALTH
How would you rate your child's current physical health? □ Poor □ Fair □ Good □ Very good
Height: _____ Weight: _____

Emergency Contact

NAME	PHONE #	RELATIONSHIP

Pediatrician's Name: _____ Phone_____
Office Location: _____ Date/Reason of Last Visit _____

List any & ALL medication(s) your child is now taking, the amount and why they're taking it:
_____
_____
_____
_____

Has your child had any surgeries/accidents/conditions requiring hospitalization or same day surgery?

DATE	HOSPITAL	REASON	STATUS

Does your child report the following eating/sleeping problems?
□ Dieting □ Weight Gain/Loss □ Refusing to eat □ Overeating □ Vomiting □ Picky Eater
□ Troubling falling or staying asleep □ Oversleeping □ Nightmares □ Soiling □ Bedwetting

How would you describe the nutritional value of your child's diet? □ Good □ Fair □ Poor

To your knowledge…

- Has your child EVER used alcohol or other substances? □ NO □ YES IF yes, what/when:
  _____
- Does your child use cigarettes or other tobacco products? □ NO □ YES
- Is your child or have they EVER been sexually active? □ NO □ YES

Has your child EVER been diagnosed or being treated for any other following…
□ ADHD □ Anemia or other Blood Disorder □ Cancer – Type: _____ □ Diabetes
□ Epilepsy/Seizure □ Chronic Ear Infections □ HIV/AIDS □ Fever
□ Lead Poisoning □ Vision or Hearing Problems □ Meningitis
□ Encephalitis □ Muscular/Skeletal Conditions □ Hydrocephalus □ Other: _____

What significant life changes or stressful events have you experienced within the past year?
_____
_____

DEVELOPMENTAL HISTORY

Health of mother: □ Good □ Fair □ Poor □ Unknown

Did mother use any substances during pregnancy? □ Alcohol □ Marijuana □ Heroin or other opiates
□ Crack/Cocaine □ Cigarettes or other Tobacco Products □ _____

Were there any concerns with pregnancy or delivery? _____

Overall their development was: □ Slow □ Normal □ Advanced

Did your child need any early intervention services? □ NO □ YES If yes, what services & the reason:
_____
_____
_____

FAMILY

Describe your child's relationships within the family: _____
_____
_____

Describe your child's religious/spiritual beliefs:_____
_____

Any family experience…

- Mental health concerns □ NO □ YES If yes, who? _____
- Substance Use concerns □ NO □ YES If yes, who? _____
- Suicide/suicide attempts □ NO □ YES If yes, who? _____
- Domestic Violence □ NO □ YES If yes, who? _____

EDUCATION/EMPLOYMENT

School _____ Grade _____ Overall Grade Point: _____

Check all that apply:

□ School/Academic Problems	□ Behavioral Concerns	□ Homework Problems
□ Concerns with Peer Relationships	□ Held back a grade	□ Advanced a grade
□ Detentions/Suspension or Expulsions	□ IEP or 504 Waiver	□ Bullying

School Clubs/Activities your child is involved in: _____

Name of Employer _____ Position _____

LEGAL HISTORY

Current or Past Involvement with the legal system (if Yes, please describe): □ NO □ YES
_____

Has your child EVER been incarcerated? □ NO □ YES # of times: _____ Dates: _____
Are you on Probation/Parole? □ NO □ YES Name/Phone Number: _____

ADDITIONAL INFORMATION

List your child's strengths _____
_____
_____

List your child's limitations _____
_____
_____

Who is important to your child? _____
_____

What does your child enjoy & do for fun? _____
_____