turnerwood

MARRIAGE AND FAMILY THERAPY, INC.

CLIENT INFORMATION SHEET (CHILDREN AND TEENS)

CLIENT INFORMATION

Name: _____ Date of Birth: _____
Address: _____ City: _____ Zip: _____
School name: _____ Grade Level: _____

PARENT INFORMATION

Name: _____
Address: _____
City: _____ Zip: _____
Date of birth: _____ Age: _____
Occupation: _____

Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email Address: _____

Name: _____
Address: _____
City: _____ Zip: _____
Date of birth: _____ Age: _____
Occupation: _____

Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email Address: _____

PARTY RESPONSIBLE FOR CLIENT (IF OTHER THAN PARENT)

Name: _____
Address: _____ City: _____ Zip: _____
Phone number: _____ Relationship to client: _____

MARITAL STATUS OF PARENTS

☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Cohabitating ☐ Remarried ☐ Divorced

OTHER CHILDREN LIVING IN THE HOME:

Name: _____ Age: _____ ☐ Child ☐ Step-child
Name: _____ Age: _____ ☐ Child ☐ Step-child
Name: _____ Age: _____ ☐ Child ☐ Step-child
Name: _____ Age: _____ ☐ Child ☐ Step-child
Name: _____ Age: _____ ☐ Child ☐ Step-child
Name: _____ Age: _____ ☐ Child ☐ Step-child

CURRENT GOALS AND CONCERNS FOR YOUR CHILD:

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

ARE YOU CONCERNED ABOUT ANY OF THE FOLLOWING PROBLEMS?

☐ Drug use	☐ Obsessions/compulsions	☐ Sexual activity	☐ Anger
☐ Alcohol use	☐ Feelings of worthlessness	☐ Suicidal thoughts	☐ Defiance
☐ Tobacco use	☐ Anxiety/panic attacks	☐ Suicide attempts	☐ Loss of control
☐ Eating problems	☐ Problems with friends	☐ Loss of appetite	☐ Depression
☐ Bullying	☐ Unexplained aches/pains	☐ Self harming behavior	

HAS YOUR CHILD HAD ANY OF THESE SYMPTOMS DURING THE LAST 30 DAYS?

☐ Experienced or witnessed a traumatic event. Please describe: _____
☐ Learned that something bad happened to a loved one. _____
☐ Has had distressing memories that won't go away. _____
☐ Has had nightmares or unusually distressing dreams. _____
☐ Been jumpy or more easily distressed than usual. _____
☐ Suddenly began avoiding people or places or things. _____
☐ Has been more irritable or weepy than usual. _____
☐ Has had sudden sleep difficulties or loss of appetite. _____
☐ Any other sudden/unexplained changes in behavior. _____

HAS YOUR CHILD EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING PROBLEMS?

☐ Intellectual disability Please describe: _____
☐ Language disorder _____
☐ Communication disorder (speech, sound, stuttering) _____
☐ Autism spectrum disorder _____
☐ Attention Deficit/Hyperactivity Disorder (AD/HD) _____
☐ Learning disorder _____
☐ Depression _____
☐ Anxiety (separation anxiety, general anxiety, panic) _____
☐ Eating disorder (anorexia or bulimia) _____

PREVIOUS COUNSELING OR THERAPY:

☐ Individual ☐ Group ☐ Psychiatrist ☐ LPCC/LMFT/LCSW
☐ Family ☐ Outpatient ☐ Inpatient ☐ Psychologist

Name of provider: _____ How long? _____
Reason for treatment: _____ Results: _____

MEDICAL INFORMATION

Date: _____ Reason: _____
Results: _____
Does your child have any chronic illnesses? If yes, please describe: _____
_____
_____

CURRENT MEDICATION

Name/dosage: _____ Prescribed for: _____ Doctor: _____
Name/dosage: _____ Prescribed for: _____ Doctor: _____
Name/dosage: _____ Prescribed for: _____ Doctor: _____

HOW DID YOU HEAR ABOUT US?

☐ Google Search ☐ Friend/Family referral ☐ Psychology Today Listing ☐ Good Therapy Listing
☐ Yelp ☐ Other (please describe): _____

IS THERE ANYTHING ELSE YOU WOULD LIKE ME TO KNOW?

_____
_____
_____
_____

I have answered these questions to the best of my knowledge.

Signature: _____ Date: _____

Signature: _____ Date: _____