New Client Information Form (Youth)

Client Name: ______________________________ **Date of Birth:** __________ **Age:** _____

Legal Sex: ☐ Male ☐ Female ☐ Non-Binary ☐ Not Specified

Gender: ☐ Male ☐ Female ☐ Other (please specify): ____________________

Preferred Pronouns: ______________________________

Address: ____
(street) (city) (state) (zip)

Client Current School & Grade : ____

Client Cell (if applicable): ________________ OK to leave a message? ☐ Yes ☐ No

Alternate Phone: ________________ OK to leave a message? ☐ Yes ☐ No

Client Email: ________________ OK to email? ☐ Yes ☐ No

Primary Care Physician & City: ____

How did you hear about our practice? ____

May we thank the referral source? ☐ Yes ☐ No

PARENT/GUARDIAN INFORMATION:

Parents' current marital status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Parent/Guardian #1 Name: ____

Parent #1 Address (if different than client): ______________________________________
(street) (city, state) (zip)

Preferred Phone: ________________________ OK to leave a message? ☐ Yes ☐ No

Email Address: ________________________ OK to email? ☐ Yes ☐ No

Parent #1 Occupation: Employer: ____________________ Position: ____________________

Parent/Guardian #2 Name: ____

Parent #2 Address (if different than client): ____
(street) (city, state) (zip)

Preferred Phone: ___________________________ OK to leave a message? ☐ Yes ☐ No

Email Address: _____________________________ OK to email? ☐ Yes ☐ No

Parent #2 Occupation: Employer: ____________________ Position: ____________________

Child currently resides with: ☐ Both Parents ☐ Parent #1 ☐ Parent #2

☐ Other (please specify): ____

If parent(s) remarried, please provide year of remarriage: Parent #1: _________ Parent #2: _________

Sibling Name(s) (if applicable)	Age	Resides with:
______________________________	_______	______________________________
______________________________	_______	______________________________
______________________________	_______	______________________________
______________________________	_______	______________________________

CLINICAL INFORMATION:

Please briefly describe your reason for seeking therapy for your child: ______________________
____
____
____

Has your child ever been in therapy or received any type of counseling before? ☐ Yes ☐ No

If yes, please list when, where and with whom you received services and the reason:
____
____

Do you have any safety concerns for your child (past or present)? (This may include, but is not limited to, aggressive behavior toward self or others or thoughts of self-harm or suicide) ☐ Yes ☐ No

If yes, please describe: ____

____

Please list any major illnesses and/or hospitalizations if applicable, with approximate dates:

____

____

Please list any current medications (name of medication and dosage, including OTC medication):

____

____

____

Has your child had any substance use issues? ☐ Yes ☐ No

Family History of substance use issues (please list/describe):

____

____

Family History of mental health issues (please list/describe):

____

____

If there is any other additional information that that you would like to share about your child and/or family, please include it below:

____

____

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____