

MINOR CLIENT PERSONAL DATA

Intuitus Group Counseling Clinic, PLLC

1464 E. Whitestone Blvd. Ste. 2001 - Cedar Park, TX 78613 - www.intuitus-group.com

Please provide the following information for my records. All information you provide here is held to the same standards of confidentiality as our therapy. Please fill out this form prior to our first session.

Date: _____ Referred By: _____ May I thank them for the referral? Y / N

Client Name _____ Male Female

Address _____ City _____ State _____ Zip Code _____

Age _____ Birthdate ____/____/_____

Parent/Guardian Name(s) _____

Emergency Contact: _____ Relation: _____ Phone # _____

Minor: In your own words, please state the nature of the main problem: _____

How would you rate how serious this problem feels to you now? (Circle one) 1 2 3 4 5
Mildly Upsetting Extremely Serious

Parent: In your own words, please state the nature of the main problem: _____

How would you rate how serious this problem feels to you now? (Circle one) 1 2 3 4 5
Mildly Upsetting Extremely Serious

What would you like to accomplish through counseling? _____

FAMILY INFORMATION

Father: Name _____ Age _____ Occupation _____

Mother: Name _____ Age _____ Occupation _____

If client is adopted, please describe: _____

Marital Status of Parents: Single Married Divorced Separated Living Together Other _____

Briefly describe minor's relationship with Father _____

With minor's Mother _____

If divorced, please specify minor's age at divorce and circumstances surrounding divorce: _____

Custody Arrangement _____

Parent primarily responsible for payment:

Name: _____ Phone: _____ May I leave a message? Yes No

Employer & Address: _____

Additional parent:

Name: _____ Phone: _____ May I leave a message? Yes No

Brothers' first names and ages _____

Sisters' first names and ages _____

Please explain if any member of the family (immediate or extended) has ever suffered from a medical or mental health condition: _____

Please mention any history of domestic violence, child abuse or sexual abuse in the family: _____

Please comment on any history of alcohol or drug use in the family: _____

MINOR'S DEVELOPMENTAL HISTORY (If yes, please describe)

Parents' Attitudes Toward Having Children _____

Complications with Pregnancy: Yes No _____

Premature Birth: Yes No _____

Age When: Crawled _____ Walked _____ Spoke First Word _____ Spoke First Sentence _____

Developmental Delays Yes No _____

Please list any known significant life changes or traumatic events: _____

MINOR'S EDUCATIONAL HISTORY (If yes, please describe)

School Grade _____ Name of current school: _____

Type of Class: Regular Accommodations/Special Education Accelerated/Advanced Gifted/Talented

School Problems? _____

Skipped a grade? Yes No _____

Held back a grade? Yes No _____

MINOR'S CURRENT FUNCTIONING (If yes, please describe)

Behavioral Problems Yes No _____

Problems with Parents Yes No _____

Problems with Siblings Yes No _____

Problems with Peer Relationships Yes No _____

Substance Use or Abuse Yes No _____

Sexually Active Yes No _____

Any Cultural Considerations Yes No _____

MINOR'S SYMPTOMS (Please check all that apply)

	Never	Seldom	Sometimes	Often	Comments
Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Phobias/Fears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nervousness/worry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Loss of temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Depressed mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Poor attention/focus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyperactivity/restlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Appetite/eating concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

MINOR'S TREATMENT/COUNSELING HISTORY

Has minor ever had any previous counseling or psychotherapy? Yes No If YES, please list from most recent:

Dates	Problem	Therapist & Location	Helpful?

Has minor ever attempted suicide? Yes No If YES, when? _____

Has minor ever been hospitalized for psychiatric reasons? Yes No If YES, when? _____

MINOR'S MEDICATION HISTORY (Please check all that apply)

	Never	Seldom	Sometimes	Often	Comments
<u>Pain Relievers</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<u>Sleep Aids</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<u>Allergy Medicine</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<u>Vitamins</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<u>Psychiatric medication</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<u>Other (please specify)</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Please list all current medications and supplements:

<u>Medication</u>	<u>Dose</u>	<u>Reason</u>

Current Weight: _____ One Year Ago: _____ Maximum: _____ When? _____

Does minor exercise regularly? Yes No How? _____

Does minor sleep well? Yes No Amount (hours): _____ Easy to get to sleep? Yes No

Physician / City / Date of last physical: _____ Phone #: _____

OTHER INFORMATION

Do you consider your family to be religious? Yes N If yes, what is your faith? _____

If yes, do you feel that your faith should be a significant part of your therapy? Yes No

Please describe: _____

If no, do you consider yourself to be spiritual? Yes No Please describe: _____

Please describe minor's religious/spiritual status, if different than family: _____

What are minor's strengths/talents: _____

Who is supportive of minor outside of family? (best friend, teacher, coach) _____

Is there anything else you think would be helpful for me to know? _____

Parent/Guardian Signature Date

Minor Signature Date

Robert Lee (RL) Turner, MA, LPC Intern Date
Supervised by Jennifer A. Madere, LPC-S