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	□	□	□	□	_____
Headaches	□	□	□	□	_____
Phobias/Fears	□	□	□	□	_____
Nervousness/worry	□	□	□	□	_____
Loss of temper	□	□	□	□	_____
Mood swings	□	□	□	□	_____
Depressed mood	□	□	□	□	_____
Poor attention/focus	□	□	□	□	_____
Hyperactivity/restlessness	□	□	□	□	_____
Stomach issues	□	□	□	□	_____
Appetite/eating concerns	□	□	□	□	_____
Pain	□	□	□	□	_____
Fatigue	□	□	□	□	_____

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
Pain Relievers	☐	☐	☐	☐	_____
Sleep Aids	☐	☐	☐	☐	_____
Allergy Medicine	☐	☐	☐	☐	_____
Vitamins	☐	☐	☐	☐	_____
Psychiatric medication	☐	☐	☐	☐	_____
Other (please specify)	☐	☐	☐	☐	_____

Please list all current medications and supplements:

Medication **Dose** **Reason**_____

_____

_____

_____

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

_____

Jessica Jewell-Elliott, MA, LMFT-A #203151 Date

Supervised by Christopher Sperling, LMFT-S #201435