CLIENT INFORMATION – CHILD/ADOLESCENT

AGES up to age 12

Today's Date: _____ Person completing the form: _____

IDENTIFYING INFORMATION

Legal Name of Child: _____

DOB: _____ Age: _____ Social Security: _____

Address: _____

City: _____ State: _____ Zip: _____

May we contact you at these phone numbers and email?

Home phone: _____ ❑Yes ❑No

Your Cell phone: _____ ❑Yes ❑No

Child's Cell phone: _____ ❑Yes ❑No

Text messaging appointment reminders? ❑Yes ❑No

Your Work phone: _____ ❑Yes ❑No

Your Email address: _____

Child's Email address: _____

REFERRAL INFORMATION

Did anyone refer you to New Leaf Therapy?

May we have your permission to thank them for the referral? ❑Yes ❑No

INSURANCE/VERIFICATION INFORMATION

Insured Name: _____ Insurance Company:_____

Policy Holder: _____ Policy Holder SS#:_____

Policy Holder DOB: _____ Insurance ID#:_____

Insurance Company Customer Service Phone #:_____

Employer:_____ EAP Available: ❑Yes ❑No Authorized: ❑Yes ❑No #Sessions:_____

Relationship to the Insured: ❑Self ❑Spouse ❑Child ❑Other

Please bring a copy of your insurance card to your appointment.

RACE ETHNICITY (Optional) ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Hispanic ☐ Native Hawaiian or Other Pacific Islander ☐ Two or more races ☐ White

PRESENTING CONCERN/REASON FOR TREATMENT

Please describe the main concern(s) that prompted you to come in. (Use additional paper if desired)

How have these concerns evolved over time?

How have these concerns impacted your daily life, your child's daily life?

How have you and/or your child tried to cope with these concerns to this point?

List your major life stressors in the past 12 months (e.g. illness, gain of new family member, death, divorce, job change).

Please describe what you would like to be different in your child's life when s/he is done with therapy?

_____

_____

_____

_____

What are your child's strengths? _____

_____

What are your child's hobbies or preferred activities? _____

_____

What areas does your child struggle in? _____

_____

FAMILY AND SOCIAL SUPPORT

Are child's parents: ❑Married/Cohabitating ❑Divorced ❑Separated

If divorced/separated, what is the status of custody and visitation? _____

_____

Names of child's parents and siblings with their ages:

Name	Age	Living with child? If no, where?
		❑Yes ❑No
		❑Yes ❑No
		❑Yes ❑No
		❑Yes ❑No
		❑Yes ❑No
		❑Yes ❑No
		❑Yes ❑No

Names of other important people to the child and their ages:

Name	Age	Living with you?
		❑Yes ❑No
		❑Yes ❑No

		❑Yes ❑No

Was the child adopted? ❑Yes ❑No If yes, ❑At Birth ❑Older, what age _____

Where is the child in the birth order of family of origin? ❑Oldest ❑Middle ❑Youngest ❑Only

Family History of … (mark all that apply)

❑Depression ❑Suicide Attempts ❑Anxiety ❑Eating Disorders ❑Psychiatric Illness

❑Violence ❑Sexual Abuse ❑Emotional Abuse ❑Alcoholism/Substance Addiction

❑Chronic Illness (please explain)_____

Other _____

How does child get along with family?

Mother ❑Excellent ❑Good ❑Fair ❑Poor

Father ❑Excellent ❑Good ❑Fair ❑Poor

Siblings ❑Excellent ❑Good ❑Fair ❑Poor

If applicable,

Birthmother ❑Excellent ❑Good ❑Fair ❑Poor Birthfather ❑Excellent ❑Good ❑Fair ❑Poor

Step-Mother ❑Excellent ❑Good ❑Fair ❑Poor Step-Father ❑Excellent ❑Good ❑Fair ❑Poor

Does child have close friends? ❑Yes ❑No

Please list the first names of child's significant friends and indicate how long s/he have had these relationships.

First Name	How long known?	How often does your child see this person outside of school hours?
		❑Daily ❑Weekly ❑Monthly ❑Yearly
		❑Daily ❑Weekly ❑Monthly ❑Yearly
		❑Daily ❑Weekly ❑Monthly ❑Yearly
		❑Daily ❑Weekly ❑Monthly ❑Yearly
		❑Daily ❑Weekly ❑Monthly ❑Yearly

TRAUMA HISTORY

Please indicate any of the following that you have experienced…

❑Death of Mother, at child's age_____ ❑Death of Father, at child's age_____

❑Death of Sibling, at child's age_____

❑Desertion by mother, at child's age_____ ❑Desertion by father, at child's age_____

❑Divorce of parents, at child's age_____ ❑2nd divorce of stepparents, at child's age_____

❑Sexual abuse, at child's age ____ for how long _____

❑Emotional abuse, at child's age_____ for how long_____

❑Verbal abuse, at child's age _____ for how long _____

❑Neglect, at child's age _____ for how long _____

❑Physical abuse, at child's age _____ for how long _____

❑Domestic violence, at child's age _____ for how long _____

MEDICAL INFORMATION

Please list all current medications/supplements your child is taking: (attach another page if needed, or bring a list to your appointment)

Current Medication	Dosage/Frequency	Effectiveness	Prescribing Physician
		❑Good ❑Fair ❑Poor	
		❑Good ❑Fair ❑Poor	
		❑Good ❑Fair ❑Poor	
		❑Good ❑Fair ❑Poor	
		❑Good ❑Fair ❑Poor	
		❑Good ❑Fair ❑Poor	
		❑Good ❑Fair ❑Poor	

Have s/he ever been prescribed medication for a psychiatric or emotional problem? ❑Yes ❑No

If yes, please describe when, from whom, and for what purpose. _____

_____

Has child experienced any recent changes in: ❑Sleep ❑Nightmares ❑Exercise ❑Sexual Desire ❑Eating/Appetite ❑Weight

How would you describe your child's overall health? ❑Excellent ❑Good ❑Fair ❑Poor

Does s/he have any current or ongoing medical concerns? _____

_____

SUBSTANCE USE INFORMATION

Has your child used alcohol? ❑Daily use ❑Occasional Use ❑Never

Does your child use tobacco or smoke? ❑Daily use ❑Occasional Use ❑Never

Began at what age? _____If quit, at what age? _____

Has your child ever used illicit drugs or been exposed while in utero (e.g. during pregnancy)? ❑Yes ❑No

If yes, please specify:

Name of Drug	Frequency of Use
Marijuana	❑Past 30 days ❑Last 12 months ❑Date of Use Last Use ❑Age of First Use:
Methamphetamine (or other stimulant)	❑Past 30 days ❑Last 12 months ❑Date of Use Last Use ❑Age of First Use:
Cocaine/Crack	❑Past 30 days ❑Last 12 months ❑Date of Use Last Use ❑Age of First Use:
Hallucinogen/PCP	❑Past 30 days ❑Last 12 months ❑Date of Use Last Use ❑Age of First Use:
Heroin/Opiates	❑Past 30 days ❑Last 12 months ❑Date of Use Last Use ❑Age of First Use:
Synthetic Marijuana	❑Past 30 days ❑Last 12 months ❑Date of Use Last Use ❑Age of First Use:
Illicit Prescription Stimulant Use (specify)	❑Past 30 days ❑Last 12 months ❑Date of Use Last Use ❑Age of First Use:
Illicit Prescription Sedative Use (specify)	❑Past 30 days ❑Last 12 months ❑Date of Use Last Use ❑Age of First Use:
Other (specify)	❑Past 30 days ❑Last 12 months ❑Date of Use Last Use ❑Age of First Use:

In general, has alcohol/drug use interfered with family, health, or interpersonal life for the child? ❑Yes ❑No

If yes, please explain: _____

Has your child had any prior substance abuse treatment? ❑Yes ❑No

If yes, please complete the following information:

When	Where	For what reason	Effectiveness
1.			❑Good ❑Fair ❑Poor
2.			❑Good ❑Fair ❑Poor
3.			❑Good ❑Fair ❑Poor

TECHNOLOGY USE INFORMATION

Does your child use technology (e.g. cell phone, computer)? ❑Yes ❑No

Does s/he sleep with a cell phone or have it on in the room where sleep? ❑Yes ❑No

Name of Software or App	Frequency of Use
Twitter	❑Constant ❑Hourly ❑Daily ❑Occasional ❑None
Snapchat	❑Constant ❑Hourly ❑Daily ❑Occasional ❑None
Instagram	❑Constant ❑Hourly ❑Daily ❑Occasional ❑None
Facebook	❑Constant ❑Hourly ❑Daily ❑Occasional ❑None
Text messaging	❑Constant ❑Hourly ❑Daily ❑Occasional ❑None
Other:	❑Constant ❑Hourly ❑Daily ❑Occasional ❑None
Other:	❑Constant ❑Hourly ❑Daily ❑Occasional ❑None

How have they used technology to cope with the presenting concerns? _____

_____

Has the use of any technology interfered with family, health, or interpersonal life for child? ❑Yes ❑No

If yes, please explain: _____

_____

Note: It is the policy of New Leaf Therapy to not *like* or *friend* on social media any current clients seeking treatment.

EDUCATION

What school does your child attend? _____Grade Level: _____

What is the name of your child's current teacher?_____

May New Leaf Therapy LLC contact the teacher? ❑Yes ❑No

How satisfied is your child in school? ❑Very Satisfied ❑Satisfied ❑Dissatisfied ❑Very dissatisfied

What are the typical grades your child receives? ❑A's ❑B's ❑C's ❑D's ❑F's

Does your child have a learning, academic, and/or emotional disability? ❑Yes ❑No

If yes, when and by whom was your child tested? _____

_____

Has your child been sent to the principal's office for discipline problems? ❑Yes ❑No

If yes, when, by whom, and why? _____

_____

How satisfied are you with your school relations? ❑Very Satisfied ❑Satisfied ❑Dissatisfied ❑Very dissatisfied

LEGAL INFORMATION

Involved with the legal system, Friend of the Court or Child Protective Services? ❑Yes ❑No

If yes, explain _____

If yes, name of DHS/CPS Worker_____Email:_____

Does your child currently have a probation or parole officer? ❑Yes ❑No

If yes, name of Officer_____Email:_____

Have you or your child been involved with the legal system in the past? ❑Yes ❑No

If yes, explain: _____

If yes, name of attorney_____Email:_____

SPIRITUAL INFORMATION

What is your child's present spiritual affiliation? What is your present spiritual affiliation? (Use initials)

❑Christian (❑Protestant ❑Evangelical ❑Catholic)

❑Mormon ❑Jehovah Witness ❑Jewish ❑Muslim Buddhist ❑Hindu

❑Atheist ❑Agnostic

Name of church or faith center: _____City:_____

How significant a role does spirituality play in your life?

❑Very significant ❑Significant ❑Somewhat important ❑None

How significant a role does spirituality play in your family life?

❑Very significant ❑Significant ❑Somewhat important ❑None

Do you want your faith and/or spiritual matters included in therapy? ❑Yes ❑No

MENTAL HEALTH TREATMENT

Has your child ever received INPATIENT psychiatric treatment (e.g. hospitalized)? ❑Yes ❑No

If yes, please fill out the information. Use additional paper if needed.

When	Where	For what reason	Effectiveness
1.			❑Good ❑Fair ❑Poor
2.			❑Good ❑Fair ❑Poor
3.			❑Good ❑Fair ❑Poor

Has your child ever received OUTPATIENT psychological services? ❑Yes ❑No

If yes, please fill out the information. Use additional paper if needed.

When	Where	For what reason	Effectiveness
1.			❑Good ❑Fair ❑Poor

2.			❑Good ❑Fair ❑Poor
3.			❑Good ❑Fair ❑Poor
4.			❑Good ❑Fair ❑Poor
5.			❑Good ❑Fair ❑Poor

Has your child ever received drug or alcohol treatment? ❑Yes ❑No

If yes, please fill out the information. Use additional paper if needed.

When	Where	For what reason	Effectiveness
1.			❑Good ❑Fair ❑Poor
2.			❑Good ❑Fair ❑Poor
3.			❑Good ❑Fair ❑Poor

OTHER

Is there anything else you would like to share or you think I should know prior to our beginning treatment?

_____

_____

_____

_____