Tricia K. Brown, Ph.D
LCPC, NCC, LLC
Registered Play Therapist- Supervisor
913- 602-9631

CLIENT INFORMATION FORM (Minor)

Please fill out this form as fully and openly as possible. All private information is held in strictest confidence, within legal limits. If certain questions do not apply, leave them blank.

GENERAL INFORMATION **PLEASE PRINT CLEARLY**

Name (First, Middle, Last)_____________________ Date of Birth ________________Age _______ Gender: M / F

Address____ Home phone ______________________

City_____________________________ State_______ Zip_____________ Grade in school__________________

School __________________________ School address _____________________ School phone ______________

Name of person providing information ____________________________ Relationship to Client ______________

Address____ Home phone

City____________________________ State_______ Zip_____________ Cell phone _______________________

Occupation _____________________ Employer ________________________ Work phone _________________

May we leave a message at home? ____ Y ____ N At work? ____ Y ____ N On cell? ____ Y ____ N

Adopted Child? ___ Yes ___ No At what age? _____ Medical/Social History of birth parents ___ Known ___ Unknown

Who has legal custody? ____

COUNSELING GOALS

What concerns or issues convinced you to seek assistance now?____

What are your *specific* counseling goals? ____

Has client participated in counseling before? ___ Y ___ N If so, please note whom provided services, where, and when:

How helpful was previous counseling experience / what were the results? ______________________________

FAMILY BACKGROUND (as it refers to your child)

Father's name__________________________________ If deceased, age of child when he passed away _______________

Age_______ Occupation_____________________ Education level__________________

Health_____________________

Lives with child _________ % of the time. Travels or is away _______% of the time

Describe his relationship with your child, past and present ____

Mother's name_____________________________ If deceased, age of child when she passed away _______________

Age_______ Occupation_____________________ Education level__________________

Health_____________________

Describe his relationship with your child, past and present ____

Marital status of the child's parents (check all that apply):

___ Parents married, together ___ Parents divorced ___ Father remarried

___ Parents not married, together ___ One parent deceased ___ Other ________________________

___ Parents separated ___ Mother remarried

Please indicate with whom the child resides ____

If child's parents are divorced, how old was the child when it occurred and how did he/she respond to it? ______________

Please list all of your child's siblings, in the order of their birth:

Name	Age	Gender	Biological/Step/Half-Sibling	Lives with your child?

Relationship to the child of anyone else living in the home

____

Please briefly describe your child's relationship with his/her siblings

____

Briefly describe the style of parenting used with the child

____

How is love expressed in your child's home?

____

How is anger expressed in your child's

home?____

RELIGIOUS ORIENTATION

How would you describe your child's family's present religious affiliation?

How important is religious commitment to your child/child's family?

Unimportant Average importance Extremely important

1 2 3 4 5 6 7

Do you desire to have your child's/family's religious beliefs and values incorporated into the counseling process?

_____Yes _____No _____Not sure (If Yes, please explain):

____

PHYSICAL AND DEVELOPMENTAL HEALTH

Child's health at birth

____

Please indicate the age at which your child accomplished each of the following:

_____ Sat alone _____ Walked alone _____ Used sentences

_____ Crawled _____ First words _____ Toilet trained

Please indicate if your child has a history of or current problem in any of the following areas:

_____ Eating problems _____ Headaches _____ Bed wetting

_____ Sleep difficulties _____ Head injuries _____ Wetting pants

_____ stomach complaints _____ Soiling pants _____ Other serious injury

Child's present health status (circle one): Excellent Good Fair Poor

On average, how many hours of **sleep** does your child get daily?

____

List any changes in sleeping patterns in the last 6 months____

List any changes in eating patterns in the last 6 months____

Name, phone, and address of your child's primary care physician

____

List any serious illnesses/operations/hospitalizations your child has had and when

____

Please list **all medications** your child is currently taking, including the frequency, dosage and purpose (*including over-the-counter medications)*

____

____

Is there a history of problems with drug or alcohol use in your family? ☐ yes ☐ no

Has your child been seeing or hearing things that other people in the same room are not seeing or hearing? ____Yes ____No

If yes, please describe

____

Has your child ever experienced or witnessed any abuse or neglect? If so, please describe

____

Check the behaviors and symptoms that client exhibits <u>frequently</u>:

loses temper easily	interrupts others	physical aggression animals or people	avoidant/withdrawn
bed wetting	forgets	rocking body	fatigued
argues with authority	giving up	shyness	anxious/nervous
homicidal threats/attempts	difficulty awaiting turn	sibling conflict	does not complete tas
can't fall asleep	views pornography	bullies/teases others	loses things
clumsiness	hyperactivity	social isolation	
deliberately annoys	impulsively	slowness to learn	blames others for owi

people			mistakes
suicidal thoughts / attempts	spiteful/vindictive	soiling	depression
sleep disturbance	mood shifts	forced sexual activity	cries frequently
excessive worrying	nail biting	stubbornness, rigidity	victim of bullies
panic attacks	night terrors	tantrums	inattention to details
stealing	nightmares	thumb sucking/ chews clothing	other (discribe)
difficulty organizing tasks	verbal aggression	fears	
angry/resentful	easily annoyed by others	difficulty concentrating	

Please give examples of how each of the symptoms checked impacts client or other people's lives. Use the back of this sheet if necessary.

EDUCATIONAL AND SOCIAL CONCERNS

Does your child enjoy school? _____ Yes _____ No
What grades does your child typically receive?

____

Have these grades changed recently? _____ Yes _____ No
Were any Grades skipped Y / N Were any Grades Repeated Y / N Has child changed schools Y/ N

If so, when and for what reason

____

List your child's primary difficulties in school: ____

How many friends does your child have? __________ Briefly describe your child's friendships

____

What are your child's hobbies and interests?

____

Has the frequency with which your child participates in these activities changed recently? _____ Yes _____ No

Thought Provoking Questions:

What do you want your child to achieve in life?

____

____

____

What has been the most significant loss your child has experienced?

____

Who is your child most connected to in his/her life?

____

Has your child, or anyone close to your child suffered from a **serious loss or trauma** ? If So, please describe

____

List your child's greatest strengths ____

List your child's greatest weaknesses____

Family History

Check all of the following family concerns that apply currently or in the last 6 months:

Marital difficulties	____	Older sibling leaving home	____
Aging grandparents	____	Recent death in family	____
Alcoholism	____	Recent death of friend	____
Serious illness of child	____	Drug addiction in family	____
Serious illness relative	____	Financial problems	____
Birth of a sibling	____	Step parent in the home	____
Move to a new house	____	Traumatic experience	____
Move to a new school	____	Other (specify) _________________	

Has there been anyone in either parent's family who has been treated for mental illness?

Y N If yes, please explain: _______________________________________

____

____

Has anyone in either parent's family been prescribed medication for depression, bipolar disorder, or anxiety?

Y N If yes, please explain: _______________________________________

____

____

Has anyone in either parent's family been treated for alcoholism or drugs?

Y N If yes, please explain: _______________________________________

____

Describe briefly any special interests, hobbies and recreational activities in which family members participate:

Child: ____

____

Mother: ____

____

Father: ____

____

Brothers/Sisters: ____

____

As legal guardian/custodial parent of the child listed above, do you give permission for him/her to receive counseling/assessment from Tricia K Brown PhD LCPC LLC ? _________

***Signature:____________________________________ Date:______________________________**