

## New Client Information (Child/Adolescent)

*Please fill out this form and bring it with you to the first session.*

### **SECTION 1: Parent Information**

Mother's Name: \_\_\_\_\_

Mother's Address:

\_\_\_\_\_

\_\_\_\_\_

Father's Name: \_\_\_\_\_

Father's Address:

\_\_\_\_\_

\_\_\_\_\_

Name of Step-parent(s):

\_\_\_\_\_

\_\_\_\_\_

Important Phone Numbers:

\_\_\_\_\_ (home) \*may I leave a message? Y N

\_\_\_\_\_ (cell) \*may I leave a message? Y N

\_\_\_\_\_ (other) \*may I leave a message? Y N

Do you like to use texting as a brief form of communication re: appointments? Y N

\* Please Note: text messages are not considered to be confidential

Email (if applicable):

\_\_\_\_\_

• Please Note: Email is not considered to be a confidential medium of correspondence

**SECTION 2: Child / Adolescent Information**

Name:

\_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Cell Phone (if applicable): \_\_\_\_\_ \*may I leave a message? Y N

Do you like to use texting as a brief form of communication re: appointments? Y N

\* Please Note: text messages are not considered to be confidential

Email (if applicable):

\_\_\_\_\_

• Please Note: Email is not considered to be a confidential medium of correspondence

Birthdate: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

School: \_\_\_\_\_

1. Have you (the child/adolescent) previously received any type of mental health services (psychotherapy, psychiatric services)? Y N  
(optional explanation):

\_\_\_\_\_

\_\_\_\_\_

2. Are you currently taking any prescription medication? Y N

A. If yes, please list medication(s): \_\_\_\_\_

\_\_\_\_\_

3. Have you ever been prescribed a psychiatric medication? Y N

A. If yes, please list medication(s): \_\_\_\_\_

\_\_\_\_\_