In order to provide the best treatment possible, please complete this questionnaire. This form can be completed by the child's parent and also along with the child if appropriate. If you are unsure about any item, or feel uncomfortable answering, please leave that part blank, and if you like, we can discuss it together in session. The information you provide is protected as confidential.

:::::Child Form:::::

Client Demographic Information for

Full legal name: _____ Date of birth: _____

Home address: _____

Phone:
(home) _____Is it okay to leave you a message at this number? Yes ___No ___
(cell/parent's cell)_____ Is it okay to leave you a message at this number? Yes ___No ___

Parent's email address: _____ Is your email address confidential? Yes __No __
Please be advised that email is not the most secure form of communication.

Gender: _____ Sexual orientation: _____

Ethnic/cultural background: _____ Native language: _____

Religious/Spiritual orientation: _____ Year in School: _____

Emergency contact #1 name: _____ phone number: _____

Emergency contact #2 name: _____ phone number: _____

Reason for Seeking Treatment

Please describe your reason(s) for seeking treatment at this time, include date or month or year the problem started: _____

_____

Was there an event which made these issues or problems surface? Yes ____ No ____

If yes, please describe: _____

What results do want from treatment?

_____

_____

Please indicate how any of the following symptoms may be bothering you

	No Problem	Mild Problem	Moderate Problem	Severe Problem
Depression				
Anxiety				
Family stress				
Loss of a loved one				
Another form of loss				
Anger				
School				
Abuse/victimization				
Sexuality				
Eating and or body image issues				
Eliminating drug/alcohol habit				

Other, please specify:

_____
_____
_____

What areas of your life are these issues impacting you (family, school, friends, etc)

_____
_____
_____

What coping strategies have helped?

_____
_____

Not helped? _____

Have you had any mental health treatment in the past? (please include names and dates if possible)

_____

_____

Have you ever been hospitalized due to mental health symptoms? (if yes please include when and for what reasons)

_____

Was there anything during these treatment episodes that was particularly helpful or unhelpful?

_____

_____

Substance Use

Do you currently struggle with substance abuse or dependence? _____
If yes please explain what this is like for you _____

Medical History

Do you have any allergies to food and/or medications? If yes, please describe: _____

Name and number of Primary Care Physician _____

Please list any prescription medications you currently use including any psychiatric medications:

_____

_____

Does anyone besides your PCP prescribe your medications? If so please indicate name and number

_____

Please list any over-the-counter medications you currently use such as vitamins, sleeping/diet pills, aspirin/pain relievers, etc., include name, dosage, and frequency: _____

_____

How often do you exercise? _____
Any recent weight gain? _____ weight loss? _____
Have you ever struggled with an eating disorder or do you currently struggle with one? _____
Do you engage in any of the following eating disorder behaviors: Purging, binging, restricting, over exercising? If yes, how often? _____

Do you have any current medical diagnoses and if so please list _____
are you being treated for this/them? If yes please share who is providing treatment _____

Do you have any medical symptoms or complaints that you are currently experiencing? Please explain.

_____

_____

Have you ever been hospitalized for a medical issue/ had any significant surgeries or procedures? If yes please state why and when _____

Family History

Has anyone in your family ever experienced any Mental Health struggles? If yes please explain

_____

_____

Has anyone in your family ever experienced any substance abuse / dependence issues? If yes please explain _____

Has anyone in your family had any significant medical problems _____

How many siblings do you have? _____ Where are you in the birth order? _____

What is your parent's marital status? _____ if divorced how old were you? _____

How would you describe the nature of your relationship with your family? _____

More about you

What are some of your hobbies/ interests?

_____

_____

What would you consider to be some of your weaknesses?

_____

What would you consider to be some of your strengths?

_____

_____

Is there anything else that you would like me to know about you that you have not already shared?

_____

_____

_____

_____

Thank you for providing me information regarding your health and well-being. I will use this information to build a treatment designed specifically to meet your needs. Please feel free to discuss any aspect of your responses with me. Thanks for your time filling out this form -*Meredith Mirsepassi*