Karis Counseling LLC – Kathy Pardue LPC
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CLIENT INFORMATION FORM

This Form is Confidential

Today's date: ________________
Your Adolescent's name:

____
Last **First** **Middle Initial**
Parent or Legal Guardian's Name:

____
Last **First** **Middle Initial**
Adolescent's date of birth: ________________ **Gender:**
Male___Female___Other________________
Parent or Legal Guardian's Social Security #:

____

Home street address:

____
City: ____ **State:** ____________
Zip:____________________

Parent or Legal Guardian's Name of Employer:

____
Address of Employer:

____
City: ____ **State:** _____________
Zip:____________________

Home Phone: _____________________________ **Work Phone:**

____
Cell Phone: ________________________ **Call restrictions?**____________ **Email:**

____

Referred by:

____

- May I have your permission to thank this person for the referral?
  Yes No
- If referred by another clinician, would you like for us to communicate with one another?
  Yes No

Person(s) to notify in case of any emergency: _______________________________

____
Name
Phone

We will only contact this person if we believe it is a life or death emergency. Please provide your signature to indicate that we may do so: (Your Signature):____

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Please briefly describe your adolescent's presenting concern(s):_______________________________________

____

____

What are your/your adolescent's goals for therapy?

____

____

____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)?_______________________________________

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses your child has had:________________

____

____

Current Medications (if you need more room, please write on the back of this page):

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous medical hospitalizations (Approximate dates and reasons):

____

____

____

Previous psychiatric hospitalizations (Approximate dates and reasons):

____

____

____

Has your adolescent ever talked with a psychiatrist, psychologist, or other mental health professional? (If yes, please list approximate dates and reasons):

____

____

____

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual __Transgender __ Asexual __In Question __Other: ______________

Racial/Ethnic Identity:

__African/African-American/Black
__American Indian/Alaska Native
__Asian/Asian-American/Asian Pacific Islander
__ Latino/Latino-American
__ Middle Eastern/Middle Eastern-American
__White/European-American

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__Bi-Racial/Multi-Racial __Not listed

FAMILY:

How would you describe your adolescent's relationship with his or her mother?_______________________________

____

How would you describe your adolescent's relationship with his or her father?________________________________

____

Are the adolescent's parents still married or did they divorce?________________ If they divorced, how old was the
child when the parents separated or divorced and how do you think this impacted him or her?
____
____

Please describe your adolescent's relationship with his or her grandparents:
____
____

Were there any other primary care givers who have had a significant relationship with your adolescent? If so, please
describe how these people may have impacted your adolescent's life:
____
____

How many sisters does your adolescent have? _____ Ages?
____

How many brothers does your adolescent have? ______ Ages?
____

How would you describe your adolescent's relationships with his or her siblings?_____________________________

____

SOCIAL SUPPORT, SELF-CARE, & EDUCATION:

POOR EXCELLENT

Adolescent's current level of satisfaction with friends and social support: 1 2 3 4 5 6 7

How would you describe your child's relationships with his/her peers?
____
____

Please briefly describe any history of abuse, neglect and/or trauma:
____
____

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Please briefly describe your adolescent's self-care and coping skills: ____
____
____

What are your adolescent's diet, weight, and exercise/activity patterns?____________________________________
____
____

Please briefly describe your adolescent's school performance and experience:________________________________
____
____

What are your adolescent's hobbies, talents, and strengths?____
____
____

PLEASE CHECK ALL THAT APPLY TO YOUR ADOLESCENT & ***CIRCLE*** THE MAIN PROBLEMS:

DIFFICULTY WITH: NOW PAST	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:		
Anxiety →			Tantrums →			Nausea →		
Depression			Parents Divorced			Stomach Aches		
Mood Changes			Seizures			Fainting		
Anger or Temper			Cries Easily			Dizziness		
Panic			Problems with Friend(s)			Diarrhea		
Fears			Problems in School			Shortness of Breath		
Irritability			Fear of Strangers			Chest Pain		
Concentration			Fighting with Siblings			Lump in the Throat		
Headaches			Issues Re: Divorce			Sweating		
Loss of Memory			Sexually Acting Out			Heart Problems		
Excessive Worry			History of Child Abuse			Muscle Tension		
Wetting the Bed			History of Sexual Abuse			Bruises Easily		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Makes Careless Mistakes		
Separation Anxiety			Hurting Self			Fidgets Frequently		
Alcohol/Drugs			Thoughts of Suicide			Impulsive		

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Drinks Caffeine	Sleeping Too Much	Waiting His/Her Turn
Frequent Vomiting	Sleeping Too Little	Completing Tasks
Eating Problems	Getting to Sleep	Paying Attention
Severe Weight Gain	Waking Too Early	Easily Distracted by Noises
Severe Weight Loss	Nightmares	Hyperactivity
Head Injury	Sleeping Alone	Chills or Hot Flashes

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems				Physical Abuse				Depression			
Legal Trouble				Sexual Abuse				Anxiety			
Domestic Violence				Hyperactivity				Psychiatric Hospitalization			
Suicide				Learning Disabilities				"Nervous Breakdown"			

Any additional information you would like to include:

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____

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