Bridges Counseling

Child/Adolescent Personal Data

This is a confidential record of your personal history. Information contained in it will not be released to anyone unless authorized by you or required by the law as explained in our consent to treatment.

Date_____ Referred By_____

Client: Name_____ Male ❑ Female ❑

Address_____ City_____ Zip Code_____

Home Phone(_____)_____ Cell Phone(____)_____Minor's Cell Phone(_____)_____

May we call you at home? Y ❑ N ❑ At Work? Y ❑ N ❑ Highest Grade Completed_____

Person to notify in case of emergency_____Phone Number_____

School Grade _____ Child's Age_____ Birthdate_____

Ethnicity: Caucasian❑ African American❑ Hispanic❑ Asian❑ Other❑_____

Would minor like spirituality/religious issues to be a part of your therapy? Y / N / Don't Know

NOTE: It is important for the client and therapist to determine together what part spiritual/religious issues will or will not take in therapy.

Minor: In your own words, please state the nature of the main problem:

Parent: In your own words, please state the nature of the main problem:

How would minor and parent rate how serious this problem feels to you?

Minor (Circle one) 1 2 3 4 5 Parent (Circle one) 1 2 3 4 5

Mildly Upsetting (1) - Extremely Serious (5)

What would parent and client like to accomplish through counseling?

I agree to be responsible for the payment of $_____per session which is payable at the time of the session.

Parent/Guardian Signature _____

Therapist Initials_____

FAMILY STATUS

Child's Parents: Father: Age_____ Occupation_____Date of Birth_____
Mother: Age_____ Occupation_____Date of Birth_____
Marital Status of Parents ❑ Single ❑ Married ❑ Divorce ❑ Separated ❑ Living Together ❑ Other

Custody Arrangement: Physical_____Legal: _____

If divorced, please specify minor's age at divorce and circumstances surrounding divorce: _____

_____

_____

If remarried, please indicate:

Date of remarriage: _____

Step-father: Name: _____ Age_____

Step-mother: Name:_____ Age_____

Siblings: Brothers' first names/DOB_____

Sisters' first names/DOB_____

MINOR'S MEDICAL CONDITIONS
Please check all that apply to you:

	NEVER	SELDOM	SOMETIMES	OFTEN
Insomnia	❑	❑	❑	❑
Loss of Appetite	❑	❑	❑	❑
Asthma	❑	❑	❑	❑
Headaches	❑	❑	❑	❑
Phobias (Fears)	❑	❑	❑	❑
Nausea	❑	❑	❑	❑
Allergies	❑	❑	❑	❑
Nervousness	❑	❑	❑	❑
Loss of temper	❑	❑	❑	❑
Fatigue	❑	❑	❑	❑
Depression	❑	❑	❑	❑
Constipation	❑	❑	❑	❑
Diarrhea	❑	❑	❑	❑
Over-eating	❑	❑	❑	❑
Mood swings	❑	❑	❑	❑
Self-Harm Behaviors	❑	❑	❑	❑
Bedwetting	❑	❑	❑	❑
Hearing/Seeing Things that are not there	❑	❑	❑	❑
Night Terrors	❑	❑	❑	❑

MINOR'S MEDICATION HISTORY
Please check all that apply to you:

	NEVER	SELDOM	SOMETIMES	OFTEN
Appetite Suppressants	❑	❑	❑	❑
Pain Relievers	❑	❑	❑	❑
Sedatives/ Tranquilizers	❑	❑	❑	❑
Sleep Aids	❑	❑	❑	❑
Stimulants	❑	❑	❑	❑
Blood Pressure Meds	❑	❑	❑	❑
Heart Medicine	❑	❑	❑	❑
Vitamins	❑	❑	❑	❑
Other (please specify)	❑	❑	❑	❑

Please list all current medications:

MEDICATION	DOSE	REASON

Comments:

Minor's Info - Current Weight_____ One Year Ago_____ Maximum_____ When_____

Hobbies _____

Physician_____ City_____ Date of last physical_____

The hardest time in minor's development was: Preschool ❑ Grade School ❑ Jr. High ❑ High School

MINOR'S TREATMENT/THERAPY HISTORY

Has minor ever had any previous counseling or psychotherapy? Y ❑ N ❑ If YES, please list from most recent:

PROBLEM	DATES	THERAPIST & LOCATION	Was Therapy Successful?

Has minor ever attempted suicide? Y ❑ N ❑ If YES, when? _____

If YES, method used: _____

Has minor ever been hospitalized for psychiatric reasons? Y ❑ N ❑

If YES, when?_____ Length of hospital stay_____