

Client History for Minors

The client and his or her parent may fill this out together.

Date: _____

First Name: _____ Last Name: _____

Home Phone: _____ Parent's Cell Phone(s): _____

Parent's Work Phone(s): _____ Client's Cell Phone: _____

Parent's Email Address(s): _____ Client's Email Address: _____

Mailing Address:

Address: _____ City: _____ Zip Code _____

Gender: Male Female Date of Birth _____ Height _____ Weight _____

Have you ever experienced guided imagery hypnosis meditation day dreaming?

Referred by: phone book internet: _____ friend: _____, doctor: _____,

therapist: _____, other: _____

If you were referred by a friend or practitioner, may I thank him or her for the referral? Yes No

Grade in school: _____

School: _____

Family/others currently living with you: (Include each person's name, relationship to you, and age.)

Parent or siblings not currently living with you: (Include each person's name, relationship to you, and age.)

If you do not have contact with certain family members, please explain: _____

Religious or Spiritual Background/Orientation: _____

Do you have any pets? No Yes—What kind of pet(s) do you have? _____

What are the names of your closest friends? _____

Do you have a boyfriend/girlfriend? No Yes—What is the name of your partner? _____

Personal interests, hobbies, extracurricular activities that you enjoy: _____

Natural environments that you enjoy: _____

Ideal weather: _____

Favorite animal(s): _____

Favorite color(s): _____

Do you have any fears? Water Heights Elevators Flying Driving Public Speaking

Animal(s): _____ Insect(s): _____ Tests Needles

Other(s): _____

Are you in general good health? _____

Health Problems: _____

Medications: _____

Allergies: _____

Primary Care Physician and the city in which he or she practices: _____

Have you had any of the following?

High Blood Pressure Heart Trouble Asthma Diabetes

Lung Trouble Back Trouble Headache Trouble

Is there anything I might need to know about your medical history? _____

Are you currently seeing a psychotherapist, psychiatrist, psychologist, other mental health professional? If so, explain: _____

Are you currently taking anti-depressants, anti-anxiety medication, or medication for ADD or ADHD? Yes No
If yes, what are you taking? _____

If you are not currently seeing a mental health care professional, have you in the past? Yes No

Do you have trouble getting to sleep or staying asleep? Not usually Sometimes Frequently

Is there any past/present substance abuse in your family? No Yes—Explain: _____

Is there any past/present violence in your family? No Yes—Explain: _____

Have there been any traumatic events in your life? No Yes—Explain: _____

Have you ever attempted or thought about hurting or killing yourself? No Yes—Explain: _____

Are you currently having suicidal thoughts? No Yes—Explain: _____

What would you like to accomplish through our work together? _____

Is there anything else you feel that I should know? _____

In case of emergency, contact: _____ Relationship to you: _____ Phone: _____

Client's Signature

Date

Signature of Parent/Guardian

Date

(If you are emailing the form, you can sign it in my office when we meet.)