PAUL VANCE, LMFT (MFC 39530)
New Child/Adolescent Client Information and History

Date of First Appointment _____ Client's Date of Birth _____

Name of Client _____

Name of Parent/Guardian (s) _____

Address _____

City _____ State _____ Zip Code _____

Home Phone (___) _____ Cell (___) _____ Email _____
Is it okay to contact you at home? (Circle) Yes No

Occupation _____ Employer_____ Education _____

Marital Status (Circle): Single; Shared Living; Married; Divorced; Widowed; 2nd Marriage. Years Married ___

Previous Counseling/Hospitalization (Circle): Yes/No Approximate Date(s) _____ Duration _____

Medical doctor: _____ (___)_____ _____
Name Phone Date of last physical

Current Medical Conditions: _____

Current Medications: _____

In Emergency contact: _____
Name & Relationship Phone

How were you referred? _____

For what concerns are you seeking counseling for your child/adolescent? How long has this been a concern?

Current sources of child's stress:

Describe the events or interactions that precipitated your concerns?

Please check those that apply to your child/adolescent:

__ Depressed mood	__Panic attacks	__High stress
__Eating disturbance	__Anger/temper	__Social skills problems
__Physical abuse	__Gender issues	__Relationship issues
__Hallucinations	__Alcohol/drug abuse	__Low energy/fatigue
__Low self-esteem	__Sleep disturbance	__Co-dependency
__Phobia/fears	__Sexual abuse	__Sexual disturbance
__Chronic pain	__Aggressive Behaviors	__Obsessive/Compulsive Issues
__Avoidant behaviors	__Suicidal thoughts	__Grief/Loss

__Other (please specify)_____

__Present/past substance use (please specify substance(s) _____

How often do you use the substance: ___/day ___/week ___/month

Current Household Members (Name, Age, Relationship):

_____ _____

_____ _____

_____ _____

_____ _____

If different, who were the previous members of your child's family in the past? List names & relationships:

_____ _____

_____ _____

_____ _____

_____ _____

Did/does anyone in your child/adolescent's family have a substance abuse problem? (Please describe)

Is/Was there a history of mental illness in your child/adolescent's family? (Please describe)

Is/Was there a history of physical or sexual abuse in your child/adolescent's family? (Please explain)

How do you hope that counseling will improve your child/adolescent's relationships?

What sources of emotional and social support does your child have? (E.g. Friends, church, sports activities)

Is there anything else of concern that you would like to share?