



**Client Information – Minor**

(All information provided here is confidential.)

Today's Date: \_\_\_\_\_

Child's name: \_\_\_\_\_ Date of birth\_\_ / \_\_ / \_\_

SSN: \_\_\_\_\_ Sex: M F

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Employer, if any: \_\_\_\_\_ Work phone: \_\_\_\_\_

Parent or guardian name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work phone: \_\_\_\_\_

How were you referred to Sarah Appleton? \_\_\_\_\_

Has your child previously received mental or behavioral health services? Yes No

If yes, when? \_\_\_\_\_ what issues were treated? \_\_\_\_\_

Is he/she currently on any medication? Yes No If yes, please list \_\_\_\_\_

What significant life changes or stressful events has he/she experienced recently?

\_\_\_\_\_

In the section below identify if there is a family history of any of the following.

If yes, please indicate the family member's relationship to the child in the space provided (father, grandmother, uncle, etc.).

	<u>Please Circle</u>	<u>List Family Member</u>
Alcohol/Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Domestic Violence	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Eating Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Obsessive Compulsive Behavior	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Suicide Attempts	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Do you and/or your child consider yourselves to be spiritual or religious? Yes No

If yes, describe your faith or belief \_\_\_\_\_

What would you like to accomplish from your time in therapy?

\_\_\_\_\_

\_\_\_\_\_