WYFS Client Information Form- Child/Adolescent

Welcome. Please take a few minutes to fill out this form. The information will help us better understand your situation as well as potential solutions in helping you get your life back on track. Please note: the information is confidential.

Type of services being sought: (*Check all that apply)* **Today's Date**:_____
☐ Individual ☐ Family

Name of Primary Client: _____ Date of Birth _____

Primary Client School_____ Grade _____

Primary Client Preferred Pronouns: ☐ he/him/his ☐ she/her/hers ☐ they/them/theirs
☐ other _____ ☐ prefer not to share

If you are not the Primary Client, please provide your name, relationship to Primary Client and the best way for us to contact you:_____

_____ _____

Emergency Contact Name and Phone: _____

Client Address: _____

City: _____Zip: _____

Email address:_____

❑ Check here if you DO NOT want email reminders of appointments.

Preferred Phone Number: _____Belonging to: _____
Messages: ❑ Voicemail message okay ❑ Leave message with other person ❑ No messages

Other Phone Number: _____Belonging to:_____
Messages: ❑ Voicemail message okay ❑ Leave message with other person ❑ No messages

Primary Care Physician(s) currently treating primary client:

*Name/Phone*_____

*Name/Phone*_____

*Name/Phone*_____

Names of other individuals living in the primary household (Please check those who will attend counseling**)**

☑	Name	Relation	Age	Employer/School	Position/Grade in School
☐					
☐					
☐					
☐					
☐					

Second Household (if applicable)
Name(s): _____

Address:_____ City: _____ Zip: _____

Phone: _____ Messages: ☐ Okay voicemail ☐Leave message with other person ☐No messages

What are the primary concerns for which you are seeking counseling?
1. _____
2. _____
3. _____

What are the goals for counseling?
1. _____
2._____
3._____

Current medications

Medication	Dose (amount, how often)	Prescribing Doctor

Previous mental health treatment (outpatient, Intensive outpatient, hospitalizations)

Type of treatment	Program	Contact	Dates of treatment

Previous mental health diagnoses

Diagnosis	Diagnostician	Date of Diagnosis

Developmental and Family History

This information is confidential. During your intake interview with your therapist, you will have time to discuss these topics further.

Please check all that apply:

During pregnancy: _____mother over 35 _____mother under 18 ____use of drugs/alcohol _____use of tobacco

_____injuries _____bed rest _____other problems:_____

Labor and Delivery: _____Cesarean Section _____ labor induced _____ Complications:_____

Conditions at Birth: _____ Jaundice _____Premature _____Trouble Breathing _____Trouble sucking

_____in NICU ____needed medical intervention (explain)_____

Other problems:_____

Birth weight: _____lbs _____oz

Did the baby have medical problems during the first year? ☐ Yes ☐ No

If yes, please explain: _____

Did bed-wetting or bed soiling occur after toilet-training? ☐ Yes ☐ No If yes, please explain: _____

_____

Did your child have any developmental delays? ☐ Yes ☐ No If yes, please explain: _____

_____

Does your child receive any additional support services at school, such as an IEP or 504 plan? ☐Yes ☐No

Please describe: _____

_____

Has your child been witness to significant arguing or violence in their home or community? ☐Yes ☐No
If yes, please explain: _____

_____

Has your child been the victim of abuse? ☐Yes ☐No If yes, please explain: _____

_____

Has your child had any issues leading to school suspension or the involvement of law enforcement? ☐Yes ☐No If yes, please explain: _____

What would you like us to know about your family's cultural background/ethnicity/religion?

_____

_____

Is anyone in the family struggling with the following? **Check all that apply**

- ☐ Parent/child conflict
- ☐ Couple concerns
- ☐ Anger issues
- ☐ Depression/hopelessness
- ☐ Anxiety/worry
- ☐ Communication problems
- ☐ Divorce/separation adjustment
- ☐ Remarriage adjustment
- ☐ Job/financial problems/unemployed
- ☐ Housing problems
- ☐ Partner violence/abuse
- ☐ Sexual abuse/rape
- ☐ Alcohol/drug concerns
- ☐ Loss/grief
- ☐ Legal issues
- ☐ Eating problems
- ☐ Sexuality/intimacy concerns
- ☐ Suicidal thoughts/attempts
- ☐ Major life changes

Please explain any identified issues: _____

_____

_____

Is there anything else that is important for your therapist to know? _____

_____

_____