Client Information for Minors

Client's Name: _____ Birthday: _____ Age: _____

Address: _____

Phone Number: _____ Text message reminders for appointments? Y/N

Referred By: _____

Please list all medications, including over the counter or herbal medications:

Medication	Dose	Prescribing Doctor	Date Started	Reason for Taking

Please list everyone who currently lives in your household:

Name: _____ M/F Age_____ Relationship to You: _____
Name: _____ M/F Age_____ Relationship to You: _____
Name: _____ M/F Age_____ Relationship to You: _____
Name: _____ M/F Age_____ Relationship to You: _____
Name: _____ ___ M/F Age_____ Relationship to You: _____

Child's School: _____ Grade Level: _____ IEP: Y/N 504 Plan: Y/N

Child's Primary Care Physician: _____

Family Composition:

Parent's marital status: Married/Divorced/Separated If separated or divorced, when: _____

Mother's Name: _____ Phone Number: _____ DOB: _____

E-mail: _____ Employer:_____

Address (if different than above):
_____

Father's Name: _____ Phone Number: _____ DOB: _____

E-mail: _____ Employer:_____

Address (if different than above):
_____

Please list all other major care providers for your child (i.e. family members, day care, preschool, etc.):

_____

_____

Please Provide an Emergency Contact:

Name: _____ Relationship to Child: _____

Phone Number: _____ Address: _____

Medical & Emotional Health History & Functioning:

Please list any medical diagnosis or chronic health struggles for your child:

_____

_____

Please list any extra circular activities, hobbies, interests, and strengths of your child:

_____

_____

Please indicate any previous services your child has received and date of most frequent appointment:

- Occupational therapy: date: _____
- Speech therapy: date: _____
- Physical therapy: date: _____
- Psychological evaluation: date: _____
- Other: date: _____

Please circle any challenges or delays your child has experienced throughout development:

o Gross motor skills (crawling, walking)	Reading	Math	Hearing
o Speech/Verbal	Writing	Sensory Processing	Visual

Please indicate which of the following are a concern regarding your child:

- Attention-deficit
- Alcohol
- Anger
- Autism
- Anxiety/worries
- Bed-wetting/soiling
- Bullying
- Concerns regarding social media
- Death in family
- Destructiveness
- Difficulty concentrating
- Disobedience
- Divorce adjustment
- Drugs
- Eating concerns
- Family relationships/conflict
- Grades
- Grief
- Health issues
- Hyperactivity
- Isolation
- Issues with step-families
- Learning disorder
- Peer relationships
- Physical fighting
- Poor self-esteem
- Pregnancy
- Sadness
- Self-injury/self-mutilation/cutting
- Sex/sexuality
- Sexual abuse
- Sleeping concerns
- Stealing
- Suicidal thoughts or attempt(s)
- Transitions between activities
- Trauma
- Truancy
- Other: _____