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Adolescent Client Information

Please complete the following:

Today's Date _____ Date of Birth_____

Name: Last _____ First_____
Home Address:_____
City:_____ Zip Code:_____

School and grade:_____
Address:_____
City:_____ Zip Code:_____

Phone: Home/Cell_____

Parents name(s)_____
_____
Address (if different):_____
_____
Phone numbers: Home/Cell_____
Work_____

Referred by:_____
Insurance Co. (if applicable):_____

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Current health status (circle): Fair Good Excellent
Date of last physical exam:_____
Current health problems:_____

History of significant illnesses, health conditions, accidents, surgeries etc.:_____
_____
_____
Physician:_____
Current medications:_____

Do you smoke? _____ If so, how much_____
Do you drink alcoholic beverages?_____ If so, what is your typical intake?_____
Do you exercise regularly?_____ If so, please indicate the type and frequency of exercise_____

Brief Description of reason for seeking therapy now:_____
_____
_____
_____

Have you had previous therapy?
(circle): individual group couples none
Name of previous therapist(s)_____
_____