HEALING HEART

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Client History and Information Questionnaire for Minor

This form is intended to be filled out by the parent or guardian of the minor client.

General Information:

Client Name: Date:

Parent or Guardian Name filling out Form:

Last 4 digits of Client's Social Security Number:

Date of Birth of Client: Ethnicity of Client:

Client's Gender: [ ] Male [ ] Female [ ] Does not identify as male or female

Home Address of Client:

Home Phone Number of Client: May we leave a message? [ ] Yes [ ] No

Work Phone Number for Parent/Guardian: May we leave a message? [ ] Yes [ ] No

Mobile Phone Number for Parent/Guardian: May we leave a message? [ ] Yes [ ] No

Email Address: May we email you? [ ] Yes [ ] No
*Please note email correspondence is not considered to be a confidential medium of communication.

Insurance Information if applicable:

If you will be using insurance to cover all or a portion of the cost for the sessions for the minor client please complete the following and allow us to make a photocopy of the client's insurance card.

Primary Insurance Company:

Emergency Contact Information for Client:

In case of an emergency, whom should we contact?

Name: Relationship:

Address: Phone Number:

Referral Source:

Who referred your child to Healing Heart, or how did you learn about the practice?

To the best of you knowledge, why was your child referred?

History Information:

Why are you seeking treatment for your child?

How long has your child experienced this problem, or when did you first notice it?

What stressors may have contributed to the current complaint or problem?

Please check anything that, to the best of your knowledge, applies to your child.

[ ] Problems at school
[ ] Problems keeping friends
[ ] Problems listening to authority figures
[ ] Problems at home
[ ] Depression/Sad/Down
[ ] High/Low energy level
[ ] Angry/Irritable
[ ] Loss of interest in activities
[ ] Difficulty enjoying things
[ ] Crying spells
[ ] Decreased motivation
[ ] Withdrawing from people/Isolation
[ ] Mood Swings
[ ] Black and white thinking/All or nothing thinking
[ ] Negative thinking
[ ] Substance abuse/dependence
[ ] Addiction (internet, porn, shopping, exercise, gaming, gambling, etc.)
[ ] Change in weight or appetite
[ ] Change in sleeping pattern

[ ] Suicidal thoughts or plans
[ ] Self-harm/Cutting/Burning
[ ] Homicidal behaviors
[ ] Poor concentration/Difficulty focusing
[ ] Panic attacks
[ ] Flashbacks/Nightmares
[ ] Hearing voices/Seeing things not there
[ ] Running away
[ ] Perfectionism
[ ] Rituals of counting things, washing hands, checking locks, stove, etc./Overly concerned about germs
[ ] Distorted body image
[ ] Concerns about dieting
[ ] Binge eating/Purging
[ ] Rules about eating/Compensating for eating
[ ] Excessive exercise
[ ] Other:

Please explain all symptoms that you checked in the space below.

Previous Treatment:

Has your child received or participated in previous counseling and/or therapy? [ ] Yes [ ] No

If yes, please fill in the chart below.

Clinician's Name	Reason for Treatment	Time Period in Treatment

What did you like/dislike about the previous treatment?

Is there any particular type of treatment you would like your child to continue?

Has your child had hospital stays for psychological concerns? [ ] Yes [ ] No

If yes, please fill in the chart below.

Hospital	Dates of Stay	Reason for Stay

Developmental and Medical History

Is there anything that may have impacted your child prior to or during birth? [ ] Yes [ ] No

If yes, please elaborate:

Did your child walk, talk, and read on time? [ ] Yes [ ] No

If not, please elaborate:

Does your child have any diagnoses (medical or psychological) that you are aware of? [ ] Yes [ ] No

If yes, please fill in the chart below.

Diagnosis	Medical Provider who Diagnosed	Date Diagnosed with Disorder

Please list below any current medications or important past medications that your child is/was on:

Medication Name	Dose	Time Period on Medication	Reason for Going on Medication	Reason for Stopping Medication	Impact of Medication or Side Effects

Please note any history of serious childhood illnesses:

Please note other health concerns, serious illnesses, conditions, head injuries or major operations requiring hospitalization during your child's lifetime:

Please explain any allergies your child has:

How would you rate your child's overall physical health?

[ ] Excellent [ ] Very Good [ ] Good [ ] Fair [ ] Poor [ ] Very Poor

Does your child have a primary care physician? [ ] Yes [ ] No

What was the approximate date of your child's last physical or routine health "check up?"

Family History for Client

Birth Location:

Was your child adopted? [ ] Yes [ ] No

Please fill in the chart below indicating all the people who live in the home with your child.

Name	**Relationship to Client** (mother, step-sister, etc.) *Please note adoptions	**Nature of Relationship** (loving, distant, tense, etc.)	**Date of Birth of Family Member**

Has your child been impacted by a divorce or separation? [ ] Yes [ ] No

If yes, please elaborate.

Has your child ever been impacted by the passing of a family member? [ ] Yes [ ] No

If yes, please elaborate.

Does your family currently have Child Protective Services involvement? [ ] Yes [ ] No

If yes, please complete the following:

Case Worker's Name: Case Worker's Phone Number:

Has your family at any point in the past had Child Protective Services involvement? [ ] Yes [ ] No

If yes, please elaborate:

Does your child have a history of neglect, or physical, emotional, or sexual abuse? [ ] Yes [ ] No

If yes, please elaborate.

Is your child currently or have they previously lived in a home with domestic violence? [ ] Yes [ ] No

If yes, please explain.

Is there a family history of substance abuse, mental illness, suicide, or violence? If yes, please elaborate.

Please note any additional family information you feel might be impacting your child's current concern.

Social History

Please describe your child's relationship with peers and/or friends.

What are your child's hobbies/interests?

Educational History

Please list your child's school, teacher, and grade level.

Does your child have an Individualized Education Plan (IEP)? [ ] Yes [ ] No

If yes, please provide details about when and why your child received an IEP.

Does your child have a 504 Plan? [ ] Yes [ ] No

If yes, please provide details about when and why your child received a 504 Plan.

Please check any situations that describe your child.
[ ] In regular classes
[ ] Home Study
[ ] Special education classes
[ ] Advanced classes
[ ] Previous suspensions
[ ] Placed in alternative school

Please provide any additional important educational information.

Substance Abuse History

Are you aware of any substance abuse problems with your child? [ ] Yes [ ] No

If yes please list any substances you are aware that your child is using and the frequency of use.

Does anyone in the home have a current or past substance abuse problem? [ ] Yes [ ] No

If yes, please elaborate.

Legal History

Has your child experienced any legal challenges? If yes, please elaborate.

Is anyone in your family currently involved in a legal situation (divorce, pending charges, being sued, etc.)? [ ] Yes [ ] No

If yes, please elaborate to the extent possible.

Additional Information

Please summarize your goals for your child at counseling/therapy.

What expectations do you have for counseling/therapy?

What are your child's strengths?

What are your child's weaknesses?

Is your child comfortable with well-behaved dogs? [ ] Yes [ ] No

Is there any additional information that you believe is important for the therapist to know in order to provide your child with the best care possible?

By signing below, you are acknowledging that the information you have provided is true to the best of your knowledge.

Signature of guardian _____ Date _____