

**Demographic - MINOR**

I want to make the most of each appointment with my clients. One way of doing this is for you to write down some basic information about the minor client in advance of their first appointment. Please fill out the following as completely and legibly as possible. The information you provide on this form is confidential and cannot be released to anyone without your explicit written consent. If you have concerns about the relevance of any information requested and wish to leave it out, please feel free to do so.

**I. Client Demographic**

Last Name	First Name	Date of Birth
Street/Mailing Address		Email Address
City	State	Zip
Phone #1 Contact at this number? <input type="checkbox"/> N <input type="checkbox"/> Y Message at this number? <input type="checkbox"/> N <input type="checkbox"/> Y		Phone #2 Contact at this number? <input type="checkbox"/> N <input type="checkbox"/> Y Message at this number? <input type="checkbox"/> N <input type="checkbox"/> Y
A. <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Other: _____ <input type="checkbox"/> Decline to State		
B. Birthplace: _____ Ethnicity: _____		

**II. Authorizing Party Demographic**

Last Name	First Name	Date of Birth
Street/Mailing Address		Email Address
City	State	Zip
Phone #1 Contact at this number? <input type="checkbox"/> N <input type="checkbox"/> Y Message at this number? <input type="checkbox"/> N <input type="checkbox"/> Y		Phone #2 Contact at this number? <input type="checkbox"/> N <input type="checkbox"/> Y Message at this number? <input type="checkbox"/> N <input type="checkbox"/> Y
Relationship to minor client		

**III. Referred by?** \_\_\_\_\_

#### IV. Emergency Contact (If different than Authorizing Party)

Last Name	First Name	
Address		
City	State	Zip
Phone #1	Phone #2	
Relationship to client		

#### V. General Health Information

Please fill out the following information:

Historical...	No	Yes	If yes, please explain:	Current...	No	Yes	If yes, please explain:
Use of tobacco products				Use of tobacco products			
Use of alcohol				Use of alcohol			
Use of illicit substances				Use of illicit substances			
Misuse of prescription drugs				Misuse of prescription drugs			
Use of caffeine				Use of caffeine			
Daily exercise				Daily exercise			

What else should I know about the minor's general health? \_\_\_\_\_

#### VI. Medical History

Pediatrician/Primary Care Physician (current) ☐ Not Applicable

Last Name	First Name	
Address		
City	State	Zip
Phone	Fax	

**A.** Is the minor currently under the care of a medical specialist? ☐ N ☐ Y *If yes, please explain:*

**B.** Has the minor ever been under the care of a medical specialist? ☐ N ☐ Y *If yes, please explain:*

**C.** Please list any *chronic illnesses, disabilities, and/or medical conditions* that the minor has been professionally diagnosed with: ☐ Not Applicable

Illness/Disability/Medical Condition	Date Diagnosed
Illness/Disability/Medical Condition	Date Diagnosed
Illness/Disability/Medical Condition	Date Diagnosed

**D.** Please list any medications, prescription and over the counter, the minor currently takes for any chronic illnesses, disabilities, and/or medical conditions. ☐ Not Applicable

Medication	Condition	Dosage (mg)
Medication	Condition	Dosage (mg)
Medication	Condition	Dosage (mg)

**E.** When was the minor's most recent physical/check-up? \_\_\_\_\_ ☐ Not Applicable

What else should I know about the minor's medical history? \_\_\_\_\_

## VII. Mental Health History

**A.** Psychiatrist (*current*) ☐ Not Applicable

Last Name	First Name	
Address		
City	State	Zip
Phone	Fax	

**B.** Psychologist, Therapist, or Counselor (*current*) ☐ Not Applicable

Last Name	First Name	
Address		
City	State	Zip
Phone	Fax	

**C.** Has the minor ever been under the care of a psychiatrist?    ☐ N    ☐ Y    *If yes, please explain:*

Dates	Psychiatrist	Circumstances
Dates	Psychiatrist	Circumstances
Dates	Psychiatrist	Circumstances

**D.** Has the minor ever received therapy and/or counseling?    ☐ N    ☐ Y    *If yes, please explain:*

Dates	Therapist/Counselor	Circumstances
Dates	Therapist/Counselor	Circumstances
Dates	Therapist/Counselor	Circumstances

**E.** Has the minor ever been admitted to a psychiatric hospital?    ☐ N    ☐ Y    *If yes, please explain:*

Dates	Hospital	Circumstances
Dates	Hospital	Circumstances
Dates	Hospital	Circumstances

**F.** Please list any *mental health conditions* that the minor has been professionally diagnosed with:  
☐ Not Applicable

Mental Health Condition	Date Diagnosed
Mental Health Condition	Date Diagnosed
Mental Health Condition	Date Diagnosed

**G.** Please list any medications, prescription and over the counter, the minor currently takes for any mental health conditions.    ☐ Not Applicable

Medication	Condition	Dosage (mg)
Medication	Condition	Dosage (mg)
Medication	Condition	Dosage (mg)

What else should I know about the minor's mental health history? \_\_\_\_\_

## VIII. Trauma History

Check the box next to the events the minor has witnessed and/or experienced, currently and/or in the past.    ☐ Not Applicable

	Yes	If yes, please explain:
Natural disaster		
Human-made disaster		
Serious accident/injury		
Chemical or radiation exposure		
Life-threatening illness		
Death of a close friend, family member, or co-worker		
Suicide of a close friend, family member, or co-worker		
Kidnapping		
Hostage situation		
Terrorist attack		
Torture		
War		
Dead bodies (not at a funeral)		
Attack with a weapon		
Injury from hitting, spanking, choking, pushing		
Forced, unwanted sexual contact		
Other:		
Other:		
Other:		

What else should I know about your trauma history? \_\_\_\_\_

## IX. Crisis/Suicide History

**A.** Is the minor currently indicating s/he is having thoughts of wanting or intending to...

- ☐ No      YES: ☐ kill themselves  
☐ die?  
☐ seriously harm themselves (without the intent to die)?

If yes to any, please explain: \_\_\_\_\_

**B.** Is the minor currently indicating s/he thoughts of wanting or intending...

- ☐ No      YES: ☐ to kill someone else?  
☐ someone else to die?  
☐ to seriously harm someone else (without the intent of death)?

If yes to any, please explain: \_\_\_\_\_

**C.** Has the minor ever, in their life, indicated s/he has had thoughts of wanting or intending to...

☐ No

YES: ☐ kill himself?

☐ die?

☐ seriously harm himself (without the intent to die)?

If yes to any, please explain: \_\_\_\_\_

**D.** Has the minor ever attempted to kill himself? ☐ N ☐ Y *If yes, please explain:*

Date	Circumstances	Result (Hospitalization, therapy, etc.)
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Date	Circumstances	Result (Hospitalization, therapy, etc.)
------	---------------	---

Date	Circumstances	Result (Hospitalization, therapy, etc.)
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**E.** Has the minor ever seriously harmed themselves (without intending to die)? ☐ N ☐ Y

*If yes, please explain:*

Date	Circumstances	Result (Hospitalization, therapy, etc.)
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Date	Circumstances	Result (Hospitalization, therapy, etc.)
------	---------------	---

Date	Circumstances	Result (Hospitalization, therapy, etc.)
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**F.** Has the minor ever seriously harmed someone else, with or without the intent of death?

☐ N ☐ Y

*If yes, please explain:*

Date	Circumstances	Result (Hospitalization, therapy, etc.)
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Date	Circumstances	Result (Hospitalization, therapy, etc.)
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Date	Circumstances	Result (Hospitalization, therapy, etc.)
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What else should I know about the minor's crisis history? \_\_\_\_\_

## X. Family History

**A.** Biological Mother: ☐ Deceased ☐ Incarcerated ☐ Unknown ☐ Other: \_\_\_\_\_

Last Name	First Name
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Occupation
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**B.** Biological Father: ☐ Deceased ☐ Incarcerated ☐ Unknown ☐ Other: \_\_\_\_\_

Last Name	First Name
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Occupation
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**C. Biological parents are:**

☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed Other: \_\_\_\_\_

**D. Does the minor have any siblings?** ☐ N ☐ Y

*If yes, please provide the following:*

Name	Age	Gender	Bio/Step/Adopted/Other	Residence
Name	Age	Gender	Bio/Step/Adopted/Other	Residence
Name	Age	Gender	Bio/Step/Adopted/Other	Residence

**E. Is there a history of *diagnosed/undiagnosed mental illness* in the minor's family?** ☐ N ☐ Y

*If yes, please explain:*

Relationship: <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	Mental Illness: <input type="checkbox"/> Diagnosed <input type="checkbox"/> Undiagnosed
Relationship: <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	Mental Illness: <input type="checkbox"/> Diagnosed <input type="checkbox"/> Undiagnosed

**F. Is there a history of *diagnosed/undiagnosed substance use disorder/addiction* in the minor's family?** ☐ N ☐ Y

*If yes, please explain:*

Relationship: <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	Substance/Addiction: <input type="checkbox"/> Diagnosed <input type="checkbox"/> Undiagnosed
Relationship: <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	Substance/Addiction: <input type="checkbox"/> Diagnosed <input type="checkbox"/> Undiagnosed

What else should I know about the minor's family history? \_\_\_\_\_

## **XI. Education and Developmental History**

**A. What school does the minor currently attend?** \_\_\_\_\_

**B. What grade is the minor currently in?** ☐ 7<sup>th</sup> ☐ 8<sup>th</sup> ☐ 9<sup>th</sup> ☐ 10<sup>th</sup> ☐ 11<sup>th</sup> ☐ 12<sup>th</sup> ☐ Other: \_\_\_\_\_

**C. Has the minor ever repeated a grade?** ☐ N ☐ Y

*If yes, please explain:*

**D. Does the minor currently receive special education services?** ☐ N ☐ Y *If yes, please explain:*

Is there a current 504 or IEP in place? ☐ N ☐ Y

**E. Has the minor ever received special education services?** ☐ N ☐ Y

*If yes, please explain:*

**F. Is the minor currently in any gifted, talented, and/or honours program?** ☐ N ☐ Y

*If yes, please explain:*

**G.** Has the minor ever been involved in any gifted, talented, and/or honours program? ☐ N ☐ Y  
If yes, please explain:

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**H.** Does the minor currently receive tutoring and/or additional education services (not special education)? ☐ N ☐ Y  
If yes, please explain:

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**I.** Has the minor ever received tutoring and/or additional education services (not special education)? ☐ N ☐ Y  
If yes, please explain:

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**J.** Please check any of the following that the minor is currently experiencing or has experienced at school:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Alcohol/Drug issues | <input type="checkbox"/> Fighting            | <input type="checkbox"/> Poor attendance |
| <input type="checkbox"/> Behaviour problems  | <input type="checkbox"/> Gang activity       | <input type="checkbox"/> Poor grades     |
| <input type="checkbox"/> Detention           | <input type="checkbox"/> Incomplete homework | <input type="checkbox"/> Suspension      |
| <input type="checkbox"/> Expulsion           | <input type="checkbox"/> Lack of friends     | <input type="checkbox"/> Other: _____    |

**K.** Is the minor currently a victim of bullying? ☐ N ☐ Y  
If yes, please explain:

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**L.** Has the minor ever been the victim of bullying? ☐ N ☐ Y  
If yes, please explain:

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**M.** Is the minor currently bullying others? ☐ N ☐ Y  
If yes, please explain:

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**N.** Has the minor ever bullied others? ☐ N ☐ Y  
If yes, please explain:

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What else should I know about the minor's educational and/or developmental history?

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## **XII. Symptoms**

**A.** What symptoms does the minor have and how long have they been active? ☐ Not Applicable

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**B.** Do these symptoms affect the minor's activities of daily living? ☐ N ☐ Y  
If yes, which ones?

- ☐ Independent Living Tasks (utilizing food, shelter, clothing, and basic living essentials appropriately)
- ☐ Social/Community Relationships (engaging in meaningful activities, connecting with others)
- ☐ Vocational/Educational Responsibilities (accomplishing home and/or school demands and requirements)
- ☐ Physical Care Routines (attending medical/mental health appointments, exercising, maintaining self-hygiene)



### XIII. Strengths and Goals

**A.** What are the minor's *strengths*? What do people like about the minor? What do YOU like about the minor?

**B.** How would you describe the minor's *self-esteem*?

**C.** What are the minor's current coping skills? What helps the minor function now?

**D.** What meaningful activities does the minor participate in and how often?

**E.** What are the minor's cultural, spiritual, or religious beliefs, if any?

**F.** Why have you sought mental health services today for the minor?

**G.** What are your *goals* for the minor as they engage in therapy?

What else should I know about the minor? \_\_\_\_\_

***I attest I am the Authorizing Party whose name appears on the first page of this document and all information provided herein is accurate and true.***

Client (PRINT)

Client (SIGNATURE)\*

DATE\*

*\*ONLY if minor client is aged 12-17 years seeking independent therapy*

Authorizing Party (PRINT)

Reason for Authorizing Representation:

☐ Client is a minor

☐ Client is deceased

☐ Other: \_\_\_\_\_

Type of Authorizing Representation:

☐ Parent with sole legal and/or physical custody\*

☐ Parent with joint legal and/or physical custody\*

☐ Legal Guardian\*

☐ Estate Representative\*

☐ Other: \_\_\_\_\_

*\* You may be required to provide documentation validating this status*

Authorizing Party (SIGNATURE)

DATE