

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 regarding the minor of concern in advance of his/her 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. Demographic

Last Name First Name

Date of Birth SSN

Street/Mailing Address Email Address

City/State/Zip

Male Female Transgender Other: _____ Decline to State

Birthplace Ethnicity Primary Language

II. General Health Information

Do any of the following apply to the minor?

A. History of...

- Use of tobacco products
- Use of alcohol
- Use of illicit substances
- Misuse of prescription drugs
- Use of caffeine
- Exercise on a regular basis

If checked, please explain...

B. Current...

- Use of tobacco products
- Use of alcohol
- Use of illicit substances
- Misuse of prescription drugs
- Use of caffeine
- Exercise on a regular basis

If checked, please explain...

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

III. Authorizing Party

Last Name First Name

Date of Birth SSN

Address

City/State/Zip

Phone #1	Phone #2
Contact at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	Contact at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No
Message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	Message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No

Relationship to minor

Does the minor live with Authorizing Party? Yes No
If no, please explain and provide Minor's residential address: _____

Address

City/State/Zip

IV. Emergency Contact

Last Name First Name

Address

City/State/Zip

Phone #1	Phone #2
Contact at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	Contact at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No
Message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	Message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No

Relationship to minor

V. Education and Development History

A. What school does the minor *currently* attend? _____

B. What grade is the minor *currently* in? 7th 8th 9th 10th 11th 12th Other: _____

C. Has the minor *ever* repeated a grade? Yes No

If yes, please explain: _____

D. Does the minor *currently* receive special education services? Yes No

If yes, please explain: _____

If yes, is there a current 504 or IEP in place? Yes No

E. Has the minor *ever* received special education services? Yes No

If yes, please explain: _____

F. Is the minor *currently* in any gifted, talented, and/or honours program? Yes No

If yes, please explain: _____

G. Has the minor *ever* been involved in any gifted, talented, and/or honours program? Yes No

If yes, please explain: _____

H. Does the minor *currently* receive tutoring and/or additional education services (not special education)? Yes No

If yes, please explain: _____

I. Has the minor *ever* received tutoring and/or additional education services (not special education)? Yes No

If yes, please explain: _____

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

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

K. Is the minor *currently* a victim of bullying? Yes No

If yes, please explain: _____

L. Has the minor *ever* been the victim of bullying? Yes No

If yes, please explain: _____

M. Is the minor *currently* bullying others? Yes No

If yes, please explain: _____

N. Has the minor *ever* bullied others? Yes No

If yes, please explain: _____

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

VI. Medical History

Pediatrician/Primary Care Physician (*current*)

Last Name First Name

Address

City/State/Zip

Phone Fax

A. Is the minor *currently* under the care of a medical specialist? Yes No

If yes, please explain type of specialist: _____

B. Has the minor *ever* been under the care of a medical specialist? Yes No

If yes, please explain when and type of specialist: _____

C. Please list any *chronic illnesses, disabilities, and/or medical conditions* that the minor has been professionally diagnosed with:

Illness/Disability/Medical Condition	Date Diagnosed
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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. Include the name of the medication, what the medication is treating, the dosage (mg), and how often the medication is taken.

Medication	Condition	Dosage (mg) per d/w/m
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Medication	Condition	Dosage (mg) per d/w/m
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Medication	Condition	Dosage (mg) per d/w/m
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What else should I know about the minor's medical history?

VII. Mental Health History

Psychiatrist (*current*)

Last Name	First Name
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Address

City/State/Zip

Phone	Fax
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Psychologist, Therapist, or Counselor (*current*)

Last Name	First Name
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Address

City/State/Zip

Phone	Fax
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A. Has the minor *ever* been under the care of a psychiatrist? Yes No
If yes, please explain:

Dates	Psychiatrist	Circumstances
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Dates	Psychiatrist	Circumstances
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Dates	Psychiatrist	Circumstances
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B. Has the minor *ever* been in therapy and/or counseling? Yes No
If yes, please explain:

Dates	Therapist/Counselor	Circumstances
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Dates	Therapist/Counselor	Circumstances
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Dates	Therapist/Counselor	Circumstances
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C. Has the minor *ever* been admitted to a psychiatric hospital? Yes No
If yes, please explain:

Dates	Hospital	Circumstances
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Dates	Hospital	Circumstances
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Dates	Hospital	Circumstances
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D. Please list any *mental health conditions* that the minor has been professionally diagnosed with:

Mental Health Condition	Date Diagnosed
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Mental Health Condition	Date Diagnosed
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Mental Health Condition	Date Diagnosed
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E. Please list any medications, prescription and over-the-counter, the minor currently takes for any mental health conditions. Include the name of the medication, what the medication is treating, the dosage (mg), and how often the medication is taken.

Medication	Condition	Dosage (mg) per d/w/m
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Medication	Condition	Dosage (mg) per d/w/m
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Medication	Condition	Dosage (mg) per d/w/m
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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, current and/or in the past.

- | | |
|---|--|
| <input type="checkbox"/> Natural disaster | <input type="checkbox"/> Terrorist attack |
| <input type="checkbox"/> Human-made disaster | <input type="checkbox"/> Torture |
| <input type="checkbox"/> Serious accident/injury | <input type="checkbox"/> War |
| <input type="checkbox"/> Chemical or radiation exposure | <input type="checkbox"/> Dead bodies (<u>not</u> at a funeral) |
| <input type="checkbox"/> Life-threatening illness | <input type="checkbox"/> Attack with a weapon |
| <input type="checkbox"/> Death of close friend | <input type="checkbox"/> Injury from hitting, spanking, choking, pushing |
| <input type="checkbox"/> Death of family member | <input type="checkbox"/> Forced, unwanted sexual contact |
| <input type="checkbox"/> Kidnapping | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hostage situation | <input type="checkbox"/> Other: _____ |

Please explain:

What else should I know about the minor's trauma history?

IX. Crisis History

- A.** Is the minor *currently* making statements indicating s/he wants or is intending to
- kill themselves?
 - die?
 - seriously harm themselves (without the intent to die)?

If yes to any, please explain: _____

- B.** Is the minor *currently* making statements indicating s/he wants or is intending
- 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* made statements indicating s/he wants or intends to
- kill themselves?
 - die?
 - seriously harm themselves (without the intent to die)?

If yes to any, please explain: _____

- D.** Has the minor *ever* attempted to kill themselves? Yes No
If yes, please explain:

Date	Circumstances	Result
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Date	Circumstances	Result
------	---------------	--------

Date	Circumstances	Result
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- E.** Has the minor ever seriously harmed themselves (*without* the intent to die)? Yes No
If yes, please explain:

Date	Circumstances	Result
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Date	Circumstances	Result
------	---------------	--------

Date	Circumstances	Result
------	---------------	--------

- F.** Has the minor ever seriously harmed someone else (*without* the intent of death)? Yes No
If yes, please explain:

Date	Circumstances	Result
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Date	Circumstances	Result
------	---------------	--------

Date	Circumstances	Result
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What else should I know about the minor's crisis history?

X. Family History

A. Biological Mother

Last Name First Name

Occupation

Deceased Incarcerated Unknown Other: _____

B. Biological Father

Last Name First Name

Occupation

Deceased Incarcerated Unknown Other: _____

C. Biological parents are: Single Married Partnered Separated Divorced Widowed

D. Does minor have any siblings? Yes No

If yes, please provide the following:

Name	Age	Brother/Sister	Bio/Step/Adopted/Other	Residence
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Name	Age	Brother/Sister	Bio/Step/Adopted/Other	Residence
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Name	Age	Brother/Sister	Bio/Step/Adopted/Other	Residence
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E. Is there a history of *diagnosed/undiagnosed mental illness* in the minor's family? Yes No

If yes, please give the relationship of the relative to the minor and the mental illness (if known).

Relationship to Minor	Mental Illness
<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal <input type="checkbox"/> Unknown	<input type="checkbox"/> Diagnosed <input type="checkbox"/> Undiagnosed

Relationship to Minor	Mental Illness
<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal <input type="checkbox"/> Unknown	<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? Yes No

If yes, please give the relationship of the relative to the minor and the substance/addiction (if known).

Relationship to Minor	Substance/Addiction
<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal <input type="checkbox"/> Unknown	<input type="checkbox"/> Diagnosed <input type="checkbox"/> Undiagnosed

Relationship to Minor	Substance/Addiction
<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal <input type="checkbox"/> Unknown	<input type="checkbox"/> Diagnosed <input type="checkbox"/> Undiagnosed

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

XI. Strengths and Goals

A. What are some *strengths* of the minor? What do you like about the minor?

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

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

D. What symptoms does the minor demonstrate and how long have they been active?

E. In your own words, what is the nature of the concern that you wish the minor to address in therapy?

F. What are *your* goals for the minor as s/he engages in therapy?

G. What are the *minor's* goals for therapy? What does s/he want to accomplish?

What else should I know about the minor?

Referred by? _____