HOLISTIC MENTAL HEALTH

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CLIENT INFORMATION Date________

Child's Name: First ____________________________ MI _____ Last______________________________

Parent/Guardian Name #1: First________________________ MI_____ Last_________________________

Parent/Guardian Name #2: First _______________________ MI _____ Last _________________________

Address (including zip code): ____

Phone: (______) ____________ - ____________ Cell (______) ____________ - ________________

Email Address: ____

May we leave a message on home phone? Yes No Cell phone? Yes No Email? Yes No

*Please note: Email correspondence is not considered to be a confidential medium of communication

What is your preferred method for receiving correspondence? This includes weekly appointment reminders and other useful information.

Circle one: Phone contact Text messages Email only Facebook/Social Media

Would you like to receive our monthly newsletter? Yes No

Date of Birth: ______/_______/_______ Age: ________ Gender: □ Male □ Female

Emergency Contact: _________________________Phone of contact person: _____________________

Referral Source: (circle one) Vocational Rehabilitation VR Counselor_____________________________

Self Friend Internet Psychology Today TV Commercial Other: ______________________________

Does your child have a primary care physician? Yes No Name and phone: _____________________

Does your child have a Psychiatrist? Yes No Name and phone: _______________________________

List Any Medication Allergies: ____

Please list all medications your child is currently taking and dosage if known:

Medication #1: _____________________________ Dosage: __________

Medication #2: _____________________________ Dosage: __________

Please list any Over the Counter medications, vitamins or herbal supplements your child is taking:

____

Name current/previous psychiatrist: _________________________Phone (____) ______- _______

Mark areas of your concern with scale of severity:

Depression (low) 1 2 3 4 5 6 7 8 9 10 (high)

Anxiety/Panic Attacks (low) 1 2 3 4 5 6 7 8 9 10 (high)

Mood Swings (low) 1 2 3 4 5 6 7 8 9 10 (high)

Anger Outbursts (low) 1 2 3 4 5 6 7 8 9 10 (high)

Difficulty with Attention/Focus (low) 1 2 3 4 5 6 7 8 9 10 (high)

Difficulty with Peer Relationships (low) 1 2 3 4 5 6 7 8 9 10 (high)

Difficulty in School (low) 1 2 3 4 5 6 7 8 9 10 (high)

Strained relationship with parent (low) 1 2 3 4 5 6 7 8 9 10 (high)

Behavioral Issues Home/School (low) 1 2 3 4 5 6 7 8 9 10 (high)

List any Mental Health Diagnosis if known:

Diagnosis #1: __________________________ Diagnosis #3: __________________________

Diagnosis #2: __________________________ Diagnosis #4: __________________________

Main purpose of your consultation (please give a brief summary of the main problems):

____

____

____

Has your child received therapy services in the past? Was therapy helpful? Yes No Why?

____

Pregnancy and Birth History (please list any risk factors that were present during pregnancy and/or birth):

____

____

____

History of Suicide Attempts Yes No Dates, how many times, method:

____

____

Self Injurious Behaviors? Yes No ____

Any serious losses in your child's life? Yes No ____

History of Substance Abuse: Yes No

If yes check all that apply, method of ingestion (where applicable) and length of use.

- Alcohol ___________________________ Methadone ___________________________
- Marijuana _________________________ Methamphetamine _____________________
- Cocaine ___________________________ Xanax ________________________________
- Opiates ___________________________ Ecstasy ______________________________
- Inhalants _________________________ Other ________________________________
- Nicotine __________________________ How Many packs per day _________________

Any other Addictive behaviors? Yes No

Eating ____

Gambling ____

Video/Computer Games ____

Sexual Behavior ____

LEGAL HISTORY

Does your child have a legal history of misdemeanor or felony law violations? Yes No

If yes please list charges and sanctions including incarcerations and probations including dates:

____

____

Is your child currently on probation? Yes No If yes, are there any pending court appearances? Yes No

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RELATIONSHIPS

Any Religious or Spiritual beliefs/practices? Yes No ____

Briefly describe your child's following relationships:

Relationship with Natural Mother: Excellent Good Fair Poor

Mother have history of substance abuse? Yes No Mental Health? Yes No ______________________

Relationship with Natural Father: Excellent Good Fair Poor

Father have history of substance abuse? Yes No Mental Health? Yes No ______________________

Relationships with Step Mother/Father: Excellent Good Fair Poor

Either have history of substance abuse? Yes No ____

Where is your child in birth order of siblings: Oldest Middle Youngest

How many siblings does your child have? __________ Mental Health History? Yes No

Please identify family history of any of the following (m=mother f=father s=sibling r=relative)

Alcohol/Substance Abuse	yes no	m f s r
Anxiety	yes no	m f s r
Depression	yes no	m f s r
Eating Disorders	yes no	m f s r
Obesity	yes no	m f s r
Obsessive Compulsive Behavior	yes no	m f s r
Schizophrenia	yes no	m f s r
Suicide Attempts	yes no	m f s r

Does your child have a history of physical abuse? Yes No

Does your child have a history of sexual abuse? Yes No

Does your child have a history of emotional abuse? Yes No

Does your child have a history of neglect? Yes No

Does your child have a history of Foster Care or placements outside the home? Yes No

Does your child have a history of Rape or Molestation? Yes No

Does your child have a history of witnessing Domestic Violence? Yes No

Does your child have close friends? Yes No Does your child engage in social activities? Yes No

Does your child play sports? Yes No

Does your child do well in school? Yes No Does your child like school? Yes No

____

What activities/hobbies does your child enjoy?

____

____

EMPLOYMENT

Is your child currently employed? Yes No Occupation: ___________________________

Overall describe your child's relationship with co-workers/supervisors:

Excellent Very Good Good Poor Very Poor

PERSONAL HABITS

How many hours per night does your child sleep on average? _____Does your child have any medical conditions affecting their sleep? Yes No ____

Does your child wake feeling rested? Yes No Does your child experience difficulty falling asleep? Staying asleep? Both?

Does your child have nightmares frequently? Yes No Does your child walk in their sleep? Yes No

Usual time to bed: ____________ Usual time to wake: ___________

Does your child take naps? Yes No Does your child sleep with Radio? Yes No TV? Yes No

Computer? Yes No Cell Phone? Yes No

How many ounces of water intake does your child have on average per day? 1 glass=8oz

None 8-16oz 24-32oz 40-48oz 56-64oz 72-80oz 88+oz

Please list in order of largest to smallest quantities all other fluid intake:

Most #1: ___________________ #2: ___________________#3: __________________

How would you describe your child's overall health?

Excellent Very Good Good Average Poor Very Poor

Does your child have a history of **Head Trauma**? Yes No

Is your child experiencing **Chronic Pain**? Yes No

If yes how long? ___________ Is your child taking pain medication? Yes No

Briefly Describe: ____

____

List any current or past medical conditions your child is experiencing or has experienced:

Current: ____

Past: ____

Avg # of Bowel Movements per day or week (circle one) ______

Avg number of times your child eats per day including snacks: ________

Does your child regularly eat breakfast? Yes No

Usual breakfast foods: ____

Does your child regularly eat lunch? Yes No

Usual lunch foods: ____

Does your child regularly eat dinner? Yes No

Usual dinner foods: ____

Avg number of fruits/fruit juices per day: _______Avg number of veggies/veg juices per day: _________

Usual snack foods: ____

Average number of times your child eats restaurant food per week: __________ Fast Food _______

Any known vitamin deficiencies your child has experienced including iron? ____________________

____

What are your expectations/goals for treatment?

Goal #1

____

Goal #2:

____

Goal #3:

____