Child/Minor Confidential Questionnaire

Patient Information

Name ______________________________
Address ______________________________
Date of Birth ______________________________
City, State, Zip ______________________________
Parent's Home Phone______________________________
Ok to leave a message? Y or N
Parent's Work or Cell Phone______________________________
Ok to leave a message? Y or N
Date of Birth ______________________________
Social Security # ______________________________
Referred by ______________________________
Emergency Contact ______________________________
Relationship and Phone ______________________________

Parent Information

Name (s) ______________________________
Address______________________________
Date of Birth ______________________________
Occupation ______________________________

Brothers/Sisters

Name Age

____
____
____
____
____

Health Information (If married, please identify answers with initials)

Name of physician ______________________________ Phone ______________________________

Current Medications Dosage Date Prescribed

____
____
____
____

Overall Health Very good ________ Average ________ Declining ________
Recent Health Changes (condition, sleep, weight, etc.) ______________________________
____
____

Significant Losses Suffered (please explain) ______________________________
____
____

Other Information

Previous Counseling Date Name of Therapist Reason for Counseling

____
____
____

Briefly describe your belief in God, and if or how you see your faith being a part of the change process.

____
____
____
____

What has brought you here today? ______________________________
____
____
____

Please circle any areas of concern you may wish to discuss during the counseling process:

stress	grief & loss	occupational concerns	sexual issues	finances
anger	faith	communication	parents/in-law	appearance
anxiety	depression	substance abuse/overuse	childhood hurts	past abuse
parenting	marital issues	relational conflicts	suicidal thoughts	abortion