3 States of Mind Counseling
11755 Pointe Place A-1 Roswell, GA 30076
3statesofmind.com

# CLIENT INFORMATION FORM

**This Form is Confidential**

**Today's date:** _____

**Your child's name:** _____
Last First Middle Initial

**Parent or Legal Guardian's Name:** _____
Last First Middle Initial

**Child's date of birth:** _____ **Gender:** _____

**Home street address:** _____

**City:** _____ **State:** _____ **Zip:**_____

**Parent or Legal Guardian's Name of Employer:** _____

**Address of Employer:** _____

**City:** _____ **State:** _____ **Zip:**_____

**Home Phone:** _____ **Work Phone:** _____
**Cell Phone:** _____ **Email:** _____
Calls will be discreet, but please indicate any restrictions:_____
_____

**Referred by:** _____
- May I have your permission to thank this person for the referral?
  ☐ **Yes** ☐ **No**
- If referred by another clinician, would you like for us to communicate with one another?
  ☐ **Yes** ☐ **No**

**Person(s) to notify in case of any emergency:** _____ _____
Name Phone

We will only contact this person if we believe it is a life or death emergency. Please provide your signature to indicate that we may do so: (Your Signature):_____

**Please briefly describe your child's presenting concern(s):**_____
_____
_____

**What are your/your child's goals for therapy?** _____
_____
_____

**MEDICAL HISTORY:**

Please explain any significant medical problems, symptoms, or illnesses your child has had:_____
_____
_____
_____

**Current Medications** (if you need more room, please write on the back of this page):

| Name of Medication | Dosage | Purpose | Name of Prescribing Doctor |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Previous medical hospitalizations (Approximate dates and reasons): _____
_____
_____

Previous psychiatric hospitalizations (Approximate dates and reasons): _____
_____

Has your child ever talked with a psychiatrist, psychologist, or other mental health professional? (If yes, please list approximate dates and reasons): _____
_____
_____

**FAMILY:**

How would you describe your child's relationship with his or her mother?_____
_____
_____

How would you describe your child's relationship with his or her father?_____
_____
_____

Are the child's parents still married or did they divorce?_____ If divorced, what is the custody arrangement (hard copy of custody paperwork is required at the time of intake) _____
_____

Please describe your child's relationship with his or her grandparents: _____
_____
_____

Were there any other primary care givers who have had a significant relationship with your child? If so, please describe how these people may have impacted your child's life: _____
_____
_____

How many siblings does your child have? _____ Ages? _____

How would you describe your child's relationships with his or her siblings?_____
_____
_____
_____

**SOCIAL SUPPORT, SELF-CARE, & EDUCATION:**

POOR EXCELLENT

Child's current level of satisfaction with friends and social support: 1 2 3 4 5 6 7

How would you describe your child's relationships with his/her peers? _____
_____

Please briefly describe any history of abuse, neglect and/or trauma: _____
_____
_____

Please briefly describe your child's self-care and coping skills: _____
_____
_____

What are your child's diet, weight, and exercise/activity patterns?_____
_____
_____

Please briefly describe your child's school performance and experience:_____
_____
_____

What are your child's hobbies, talents, and strengths?_____
_____
_____

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD & ***CIRCLE*** THE MAIN PROBLEM:

| DIFFICULTY WITH: | NOW | PAST | | DIFFICULTY WITH: | NOW | PAST | | DIFFICULTY WITH: | NOW | PAST |
|---|---|---|---|---|---|---|---|---|---|---|
| Anxiety → | | | | Tantrums → | | | | Nausea → | | |
| Depression | | | | Parents Divorced | | | | Stomach Aches | | |
| Mood Changes | | | | Seizures | | | | Fainting | | |
| Anger or Temper | | | | Cries Easily | | | | Dizziness | | |
| Panic | | | | Problems with Friend(s) | | | | Diarrhea | | |
| Fears | | | | Problems in School | | | | Shortness of Breath | | |
| Irritability | | | | Fear of Strangers | | | | Chest Pain | | |
| Concentration | | | | Fighting with Siblings | | | | Lump in the Throat | | |
| Headaches | | | | Issues Re: Divorce | | | | Sweating | | |
| Loss of Memory | | | | Sexually Acting Out | | | | Heart Problems | | |
| Excessive Worry | | | | History of Child Abuse | | | | Muscle Tension | | |
| Wetting the Bed | | | | History of Sexual Abuse | | | | Bruises Easily | | |
| Trusting Others | | | | Domestic Violence | | | | Allergies | | |
| Communicating with Others | | | | Thoughts of Hurting Someone Else | | | | Often Makes Careless Mistakes | | |
| Separation Anxiety | | | | Hurting Self | | | | Fidgets Frequently | | |
| Alcohol/Drugs | | | | Thoughts of Suicide | | | | Impulsive | | |
| Drinks Caffeine | | | | Sleeping Too Much | | | | Waiting His/Her Turn | | |
| Frequent Vomiting | | | | Sleeping Too Little | | | | Completing Tasks | | |
| Eating Problems | | | | Getting to Sleep | | | | Paying Attention | | |
| Severe Weight Gain | | | | Waking Too Early | | | | Easily Distracted by Noises | | |
| Severe Weight Loss | | | | Nightmares | | | | Hyperactivity | | |
| Head Injury | | | | Sleeping Alone | | | | Chills or Hot Flashes | | |

**If you have noted any physical health problems above, please list your current medical providers and date of last appointment:**

_____

_____

_____

**FAMILY HISTORY OF (Check all that apply):**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Drug/Alcohol Problems | | | | Physical Abuse | | | | Depression | | | |
| Legal Trouble | | | | Sexual Abuse | | | | Anxiety | | | |
| Domestic Violence | | | | Hyperactivity | | | | Psychiatric Hospitalization | | | |
| Suicide | | | | Learning Disabilities | | | | "Nervous Breakdown" | | | |

**Any additional information you would like to include:**

_____

_____

_____