Gina Candelaria, M.Ed., M.C., LPC

Minor Client Initial Information Form

Child's Name: _____ Date of Birth:_____

Address: _____

Street City State Zip

Name of Parents/Guardians: _____

Phone Number:_____ Alt #: _____

Emergency contact: _____

Name Relationship Phone Number

May I contact you at home? __ Yes __No by Mail? __ Yes __ No

Are parents divorced? __ No __ Yes: Other parent's name and address:

_____

Child's School: _____ Age: _____Grade:_____

Teacher's Name(s): _____

Is your child performing to his/her academic potential? __ Yes __ No

Does your child have difficulty with making and keeping friends? __ Yes __ No

Does your child have any special education needs? __ Yes __ No

If yes, please check all that apply: __ Reading __Math __Written Expression
__Speech & Language __ Occupational Therapy __Physical Therapy __Other

__OHI, please specify category: _____

Extracurricular Activities/Sports: _____

How long in this sport/activity? _____

How many schools has your child attended since starting Kindergarten? _____

What concerns do you have for your child currently? _____

_____

_____

_____

WHEN did these concerns first start? _____

WHAT have you tried on your own to solve these concerns? _____

_____

_____

How did your child respond to these strategies? _____

_____

Has your child had previous Counseling? _____If yes, what insights were gained?

_____

How did your child respond to previous counseling? _____

_____

What changes do you want to see as a result of Counseling? _____

_____

_____

HOUSEHOLD MEMBERS:

Names: Age: Relationship:

_____

_____

_____

_____

Pets: _____

CHILD'S MEDICAL HISTORY:

Medical Issues: _____

_____

Allergies: _____

Accidents/Injuries: _____

Hospitalization(s): _____

Surgeries: _____

Food Restrictions: _____

Is your child currently under a Doctor's Care? __Yes __No If yes, for what condition is your child being treated? _____

Date of his/her last physical exam? _____

Other Doctors involved in your child's care: _____

Child's Primary Care Physician: _____

What medications is your child currently taking? (Include Supplements, Vitamins, etc)

Medication Name Dosage Prescribing Doctor Reason Prescribed

_____

_____

_____

Please check all that apply regarding the presence of familial mental health histories:

____Anxiety _____ Depression ____ Bi-Polar Disorder

____ OCD ____ ODD ____ Personality Disorders _____Eating Disorder

__Trauma History Other: _____

Thank you for sharing this information with me. Gina Candelaria

_____

Parent(s) Signature(s) Date