CHILD/ADOLESCENT - New Client Information

HOPE WILSON COUNSELING
Hope Wilson, PCC, LICDC
(PLEASE PRINT)

Child's Name _____ **Age** _____ **Date of Birth** _____
Parent's Name (s) _____
Patient status: Single_____**Married**_____ **Partnered**_____**Widowed**_____**Other**_____
Home phone_____**Cell**_____**Work**_____
Email_____
If separated or divorced, effective date_____ **(please provide copy of custody agreement)**
Are both parents aware of the child's coming into therapy? No _____ **Yes** _____
Address_____ **City**_____ **Zip**_____
If applicable, name, address and phone number of child's other parent? _____
_____
Patient relationship to insured: Self_____**Spouse**_____**Child**_____**Other**_____

Is your child adopted? No _____ **Yes** _____
Please list names/ages/relationships of everyone residing in the home? _____
_____
_____

Medical information:

Your Doctor's name/address/phone_____
Your Psychiatrist's name/address/phone_____
Significant medical conditions/disabilities_____
Current medications, dose, purpose _____
_____
Prescribing Doctor _____
Emergency contact_____
Contact relationship_____
Contact address/phone_____
What concerns you regarding your child? _____
_____
_____
_____
_____
Briefly describe how these problems affect your child's functioning_____
_____
_____

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Has your child had previous counseling, psychotherapy, or under care of a psychiatrist? If yes, please name with whom, approximate length of treatment? ___________________________________

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What would you like your child to gain from psychotherapy? __________________________________

____

____

History of thoughts, attempts, threats of suicide? ____

____

To your knowledge, does your child feel suicidal at this time? No _____ Yes _____

Past hospitalizations? ____

History or issues with alcohol and other drugs, cutting/self injuring behaviors, eating issues, restricting, purging, binging? No _____ Yes _____

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Family history of mental illness and/or addictions? ____

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I understand that payment is due at the time of services and agree to this contract of payment for services rendered. <u>I understand I need to give 24 hours notice or I will be charged for the time that was reserved for my child/adolescent.</u>

Signature ____ Date ___________________