

MINOR CLIENT INFORMATION AND HISTORY

Name: _____ Date: _____

Mailing Address: _____ D.O.B: _____

_____ Ok to send mail? Yes No

Client Phone : _____ Email: _____

Ok to leave messages? Yes No, Text*? Yes No Ok to send messages*? Yes No

Mother's Name: _____ Phone: _____ Email: _____

Ok to contact/leave message? Yes No Ok to send messages*? Yes No

Father's Name _____ Phone: _____ Email: _____

Ok to contact/leave message? Yes No Ok to send messages*? Yes No

**Please know electronic forms of communication can not be considered confidential and by checking "yes" you understand/agree to such communication being used even though confidentiality can not be assured*

Who has legal custody? Joint Mother Father Other: _____

Emergency Contact Name: _____ Phone: _____

Relationship to you: _____

Are you currently a student? Yes No Grade: _____ School: _____

Are you currently employed? Yes No Employer: _____ Position: _____

How did you hear about Four Corners Counseling? _____

Please answer the following:

What brought you to counseling today? How long have these issues been causing you distress?

Have you had thoughts that you'd be better off dead or of hurting yourself in some way? Yes No

Have you ever attempted suicide? Yes No Have any family members ever attempted suicide? Yes No

Do you or have you engaged in self-harming behaviors (i.e. cutting)? Yes No

Have you ever been to counseling in the past? Yes No

Have you ever been hospitalized for a psychiatric illness? Yes No

Have you ever been arrested, incarcerated, and/or involved in litigation? Yes No

Please indicate, if desired, your preferred gender identity _____

Please indicate, if desired, your preferred sexual orientation _____

Please explain any positive responses above:

Please list any past/current physical health problems

Please list all current medications, dose, and prescribing physician

Is there anything else you think I should know? _____