Gail M. Yost and Associates

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Client Information Form for Minors

Please bring this completed form to your first session.

Please provide the following information for our records. Leave blank any questions you would rather not answer or does not apply. All information given by you is confidential unless released by written consent except as otherwise required by law.

Date: _____

Name: _____ Birthdate: _____ Gender: _____

Name of Parent/Guardian: _____

Parents are: (Circle) Married Separated Divorced In process of divorce Never married

In the event of parents' separation and/or divorce, the court has set the following custody stipulations:

Physical Custody: (Circle) mother father full joint/shared other

Legal Custody: (Circle) mother father full joint/shared other

Legal Guardianship: Relationship_____ Documents_____

Have you had previous psychotherapy: Yes or No

Previous therapist's name:_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? Yes or No

If yes, please list:_____

If no, have you previously been prescribed psychiatric medication? Yes or No

If yes, please list:_____

Health and Social Information

How is your physical health at present? (Circle) Poor Unsatisfactory satisfactory Good Excellent

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____

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Are you having any problems with your sleep habits? Yes or No

If yes, check where applicable: Sleeping too little_____ Sleeping too much_____ Poor quality sleep____

Disturbing dreams_____ Other_____

How many times per week do you exercise?_____ Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? Yes or No

If yes, check where applicable: Eating less _____ Eating more _____ Binging _____ Restricting _____

Have you experienced significant weight change in the last 2 months? Yes or No

Do you regularly use alcohol? Yes or No

If yes, in a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

How often do you engage recreational drug use? (Circle) Daily Weekly Monthly Rarely N/A

Have you had suicidal thoughts recently? (Circle) Frequently Sometimes Rarely Never

Have you have them in the past? (Circle) Frequently Sometimes Rarely Never

Are you currently in a romantic relationship? Yes or No

If yes, how long have you been in this relationship? _____

On a scale of 1-10, 1 being very poor and 10 being outstanding, how would you rate the quality of your current relationship: _____

Do you currently feel safe in this relationship? Yes or No

In the last year, have you experienced any significant life changes or stressors? _____

_____

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Have you experienced?

Extreme depressed mood	Yes or No	Wild mood swings	Yes or No
Rapid speech	Yes or No	Extreme anxiety	Yes or No
Panic attacks	Yes or No	Phobias	Yes or No
Sleep disturbances	Yes or No	Hallucinations	Yes or No

Have you experienced?

Unexplained losses of time	Yes or No	Unexplained memory lapses	Yes or No
Alcohol/substance abuse	Yes or No	Frequent body complaints	Yes or No
Eating disorder	Yes or No	Body image problems	Yes or No

Repetitive thoughts (e.g.,obsessions) Yes or No

Repetitive behaviors (e.g., frequent checking, hand-washing) Yes or No

Homicidal thoughts Yes or No

Suicide attempt Yes or No

Occupational Information:

Are you currently employed? Yes or No

If yes, who is your current employer/position? _____

If yes, are you happy at your current position? Yes or No

Please list any work-related stressors, if any: _____

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Religious/Spiritual Information:

Do you consider yourself to be religious? Yes or No

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? Yes or No

Sexual Health History:

Are any of your current concerns related to your sexuality? Yes or No

If yes, what are your concerns? _____

Do you have any current/past experience with sexual abuse or trauma? Yes or No

Family Mental Health History:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Circle any that applies and list family member, e.g., sibling, parent, uncle, etc.):

Difficulty	**Family member**
Depression	Yes or No _____
Bipolar Disorder	Yes or No _____
Anxiety Disorders	Yes or No _____
Panic Attacks	Yes or No _____
Schizophrenia	Yes or No _____
Alcohol/Substance Abuse	Yes or No _____
Eating Disorders	Yes or No _____
Learning Disabilities	Yes or No _____

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Trauma History Yes or No _____

Suicide Attempts Yes or No _____

Other Information:

1. What do you consider to be your strengths?

2. What do you like about yourself?

3. What are effective coping strategies that you've learned?

4. What are your goals for therapy?

Favorite Things:

Therapy is really about having a good relationship with someone you can trust. The best way for us to have a good relationship is to get to know each other. So, if you don't mind a few more questions to let me get to know you:

What is your favorite movie? _____

What is your favorite song? _____

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What is your favorite TV show(s)? _____

What is your favorite thing to do with friends?_____

What are you really scared of? _____

What makes you really happy?_____

What do you think is the most important thing I should know about you?