

Care Centered Counseling, LLC
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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: _____

Parent or Legal Guardian's Social Security #: _____

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? _____

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		

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:
