INSIGHTS COLLABORATIVE THERAPY GROUP
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NEW CLIENT INFORMATION (Minor)

Today's Date: _____

Child's Name: _____ Date of Birth: _____ Age: _____

Person completing this form: _____ Relationship to Child: _____

PARENTS' RELATIONSHIP

□married □never married □separated
□unmarried living together □divorced □other:_____

PARENTS INFORMATION

Parent 1	Parent 2
Parent 1's Name: _____	Parent 2's Name: _____
Parent 1's Address: _____	Parent 2's Address: _____
City: _____ State: ____ Zip: _____	City: _____ State: ____ Zip: _____
Home Phone:_____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____
Work Phone: _____	Work Phone: _____
Email Address: _____	Email Address: _____
Occupation: _____	Occupation: _____

Parent 1 Contact Permissions:

May we contact you at home? □yes □no
May we leave a message at home? □yes □no
May we contact you at work? □yes □no
May we leave a message at work? □yes □no
May we contact you by email? □yes □no
May we contact you by cell phone? □yes □no
May we leave a message on your cell? □yes □no

Parent 2 Contact Permissions:

May we contact you at home? □yes □no
May we leave a message at home? □yes □no
May we contact you at work? □yes □no
May we leave a message at work? □yes □no
May we contact you by email? □yes □no
May we contact you by cell phone? □yes □no
May we leave a message on your cell? □yes □no

Please keep in mind that communications via email over the Internet are not secure. Although unlikely, there is a possibility that information included in an email can be intercepted and read by other parties besides the person to whom it is addressed.

Persons Living with Parent 1
(name, age, sex, relationship)

_____
_____
_____
_____
_____
_____

Persons Living with Parent 2
(if different from Parent 1)
(name, age, sex, relationship)

_____
_____
_____
_____
_____
_____

In addition to those persons already named, what are the names and relationships of all persons (adults and children) who are significant in your Child's life: _____
_____

School: _____ Grade: _____

Teacher: _____ Phone: _____

If we think it is appropriate, may we contact your child's teacher to discuss your Child's case? □yes □no

School Counselor: _____ Phone: _____

If we think it is appropriate, may we contact your child's school counselor to discuss your Child's case? □yes □no

Does your child enjoy school? □yes □no Is there anything stressful about his/her current school situation? □yes □no

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Home phone: _____ Work phone: _____

Cell Phone: _____ Permission to Contact in Emergency □yes □no

SOCIAL INFORMATION

What is the cultural or ethnic identity you claim for the Child?: _____

What is the religious orientation of the Child (if any)?: _____

Friendships:

Does your Child make friendships easily? □yes □no
Does your Child have difficulty maintaining friendships? □yes □no
What's your Child's comfort level in social situations _____
How many close or "best friends" does your Child have _____

What hobbies or special interest does your Child currently have?: _____

WHAT BRINGS YOUR CHILD TO INSIGHTS?

Who referred you to Insights?: _____

May we contact that person and say thank you? □yes □no

Briefly describe what brought your Child to Insights: _____
_____
_____

How concerned are you about the problem(s) that brought your Child to Insights?
□no concern □little concern □moderate concern □serious concern □very serious concern

What do you hope to accomplish in your Child's therapy?: _____
_____
_____

Has your Child ever been seen for counseling or therapy (include licensed professional counselors, psychiatrists, psychologists, social workers and religious counselors): □yes □no If yes:
counselor's name: _____ dates and duration of counseling: _____
reason for counseling or therapy: _____
_____

Insights is a training facility. Do you consent for a Masters/ Ph.D. Level Intern to sit in on your Child's sessions from time to time?
□yes □no

MEDICAL/EMOTIONAL INFORMATION

Child's Primary Physician's Name: _____ Phone: _____
If we think it is appropriate, may we contact your physician to discuss your Child's case? □yes □no

Child's Psychiatrist's Name: _____ Phone: _____
If we think it is appropriate, may we contact your psychiatrist to discuss your Child's case? □yes □no

Date of Child's last physical: _____

What medications (prescribed and over-the-counter) is your Child taking and for what purpose?

Medication	Purpose	When started	Prescribed By

_____

_____

(Use the back of this page if there are additional medications)

Please list all your Child's medical treatments and operations within the last year: _____

_____

Please list all your Child's current illnesses or disabilities: _____

_____

Please list any learning disabilities of your Child : _____

Do any of these behaviors apply to your Child?

History of violent behavior

□yes □no If yes, describe_____

Suicide attempts

□yes □no If yes, describe_____

Suicide plans

□yes □no If yes, describe_____

Suicidal thoughts

□yes □no If yes, describe_____

Sexual abuse

□yes □no If yes, describe_____

Physical abuse

□yes □no If yes, describe_____

Emotional abuse

□yes □no If yes, describe_____

Has your Child ever been hospitalized for an emotional disorder, eating disorder, chemical dependency, etc.?

□yes □no If yes, describe_____

Briefly list what you think are your Child's personal strengths and weaknesses (personality, character, intellect, skills, talents, achievements, etc.)

Strengths	Weaknesses

Check any of the following that apply to your Child:

□Palpitations	□Fatigue/low energy	□Poor concentration
□Poor grooming	□Mood swings	□Feel panicky
□Racing thoughts	□Sexual problems	□Feel lonely
□Feel inferior	□Anger	□Children having problems
□Career problems	□Unable to sit still	□Loss of interest in sex
□Fainting spells	□Nightmares	□Feeling depressed
□Difficulty making or keeping friends	□Education	□Easily distracted
□Spouse problems	□Problems w/ prescription drugs	□Problems with alcohol
□Abuse of non-prescription drugs	□Blackouts/temporary memory loss	□Excessive sleeping
□Feeling "on top of the world"	□Inability to control thoughts	□Feeling "numb" or cut off from emotions

□Compulsive sexual behavior	□Dizziness	□Appetite loss or increase
□Bedwetting	□Insomnia	□Tremors
□Sexual trauma	□Difficulty having fun	□Poor home environment
□Legal problems	□Self-control	□Parenting difficulties
□Lose time	□Compulsive behavior	□Divorce
□Bowel disturbances	□Unable to relax	□Memory problems
□Financial problems	□Hyperactivity	□Feeling fat
□Suspicious of other people	□Crying spells	□Hearing voices
□Lack of motivation	□Excessive boredom	□Relationship problems
□Procrastination	□Drink too much	□Work too hard
□Suicidal thoughts	□Aggressive behavior	□Odd behavior
□Nervous tic	□Trouble sleeping	□Trouble keeping job
□Take too many risks	□Agitation/irritability	□Anxiety
□Phobias/fears	□Oppositional	□Social isolation
□Hopelessness	□Grief	□Physical pain
□Self-injury	□Hallucinations	□Anorexia
□Bingeing/purging	□Excessive laxative or diuretic use	□Emotional trauma
□Substance abuse	□Anxiety attacks	□Physical trauma

Is there anything we have forgotten to ask that you think is important for us to know about your Child? _____

_____

_____

IF THE CHILD'S PARENTS ARE UNMARRIED, DIVORCED OR DIVORCING, PLEASE ATTACH COPIES OF ALL CURRENTLY APPLICABLE CHILD CUSTODY/CONSERVATORSHIP AND VISITATION AGREEMENTS AND COURT ORDERS AS WELL AS ANY DIVORCE DECREE.

_____

Parent 1 Signature Date

_____

Parent 2 Signature Date