Richard S. Williams, LMFT
Gregory Wood, MFT Registered Intern
Helena Turner, MFT Registered Intern
2020 Coffee Road, Suite H4
Modesto, CA 95355

Client Information Sheet for Children and Teens

☐ Male ☐ Female

Client Name:____Date of Birth:___________Age:_______

Address:____City:_____________Zip:_____________

Parent information:

Parent Name: ____________________________
Address: _______________________________
City: __________________Zip:______________
Date of birth:____________ Age:____________
Occupation: _____________________________

Home Phone:_____________________________
Work Phone:_____________________________
Cell Phone:______________________________

Parent Name: ____________________________
Address: _______________________________
City: __________________Zip:______________
Date of birth:____________ Age:____________
Occupation: _____________________________

Home Phone:_____________________________
Work Phone:_____________________________
Cell Phone:______________________________

Party responsible for client (if other than parent):

Name: ____

Address: _____________________________________City:___________________Zip:_____________

Phone number:____Relationship to you:____________

Marital status of parents:

☐Single ☐Married ☐Separated ☐Widowed ☐Cohabitating ☐Remarried ☐Divorced

Other children living in the home:

Name:____Date of Birth:________________ Age:_______

Name:____Date of Birth:________________ Age:_______

Name:____Date of Birth:________________ Age:_______

Name:____Date of Birth:________________ Age:_______

Name:____Date of Birth:________________ Age:_______

School information:

Name of school:____Grade: _________________

Address: _____________________________________City:___________________Zip:_____________

School phone number:___________________________School fax number:________________________

© 2013 Richard S. Williams, LMFT and Associates. All rights reserved.

Richard S. Williams, LMFT
Gregory Wood, MFT Registered Intern
Helena Turner, MFT Registered Intern
2020 Coffee Road, Suite H4
Modesto, CA 95355

Client Information Sheet for Children and Teens

Developmental history:

Parents: Complications during pregnancy (illness, stressors, etc)?______________________________________

____

Parents: Difficulties during childbirth?____

____

Developmental milestones:

Age first walked: ________________Age first talked:________________Age potty-trained:______________

Major issues or trauma as an infant or toddler (0-3): ____

____

____

____

Other developmental issues:____

Health insurance coverage:

Name of insurance company:__________________________________Phone:_______________________

Plan or policy #: ______________________Certificate #___________________Individual ID:____________

Name of insured if different than client:____

Medication:

Name/dosage: ________________________Prescribed for:__________________Doctor:_________________

Name/dosage: ________________________Prescribed for:__________________Doctor:_________________

Name/dosage: ________________________Prescribed for:__________________Doctor:_________________

Allergies:____

Current goals and concerns (list your reasons for coming to counseling):

1. ____
2. ____
3. ____
4. ____
5. ____

© 2013 Richard S. Williams, LMFT and Associates. All rights reserved.

Richard S. Williams, LMFT
Gregory Wood, MFT Registered Intern
Helena Turner, MFT Registered Intern
2020 Coffee Road, Suite H4
Modesto, CA 95355

Client Information Sheet for Children and Teens

Have there been any major changes in:

- ☐ Eating habits
- ☐ Social activities
- ☐ School responsibilities
- ☐ Living arrangements (moved)
- ☐ Family responsibilities
- ☐ Physical health
- ☐ Sleeping habits
- ☐ Exercise habits
- ☐ Other:______________________

Indicate each stressor the child or family has experienced during the last six months:

- ☐ Loss of job
- ☐ Hospitalization
- ☐ Stopped smoking
- ☐ Pregnancy
- ☐ Retirement
- ☐ Suicidal thoughts
- ☐ Suicide attempts
- ☐ Sexual difficulties
- ☐ New family member
- ☐ Feelings of worthlessness
- ☐ Panic or anxiety attacks
- ☐ Death of a close friend
- ☐ Death of close family member
- ☐ Financial difficulties
- ☐ Arrest or pending charges
- ☐ Incarceration/ conviction
- ☐ Major accident/injury/ illness
- ☐ Involved in lawsuit
- ☐ Increase in number of arguments
- ☐ Outstanding personal achievement
- ☐ Anger management problems
- ☐ Other self-control problems
- ☐ Alcohol or drug problems
- ☐ Significant weight loss/ gain
- ☐ Significant changes in memory or attention

Social and emotional health:

☐ Never	☐ Sometimes	☐ Often	My child daydreams a lot.
☐ Never	☐ Sometimes	☐ Often	My child has difficulty focusing or concentrating.
☐ Never	☐ Sometimes	☐ Often	My child seems depressed.
☐ Never	☐ Sometimes	☐ Often	My child is impulsive.
☐ Never	☐ Sometimes	☐ Often	My child has nightmares.
☐ Never	☐ Sometimes	☐ Often	My child loses his or her temper easily.
☐ Never	☐ Sometimes	☐ Often	My child has difficulty making friends.
☐ Never	☐ Sometimes	☐ Often	My child is disorganized.
☐ Never	☐ Sometimes	☐ Often	My child is hyperactive.
☐ Never	☐ Sometimes	☐ Often	My child blames others for his or her mistakes.
☐ Never	☐ Sometimes	☐ Often	My child gets along with his or her teachers.
☐ Never	☐ Sometimes	☐ Often	My child is a bullying victim.
☐ Never	☐ Sometimes	☐ Often	My child bullies other children.

© 2013 Richard S. Williams, LMFT and Associates. All rights reserved.

Richard S. Williams, LMFT
Gregory Wood, MFT Registered Intern
Helena Turner, MFT Registered Intern
2020 Coffee Road, Suite H4
Modesto, CA 95355

Client Information Sheet for Children and Teens

Relationships with family members and friends:

Describe your relationship with your child: ____
____
____
____

Describe your child's relationships with his or her siblings:______________________________
____
____
____

Describe your child's relationships with his or her peers:________________________________
____
____
____

Previous counseling or therapy:

- ☐ Individual
- ☐ Couple
- ☐ Family
- ☐ Group
- ☐ Outpatient
- ☐ Inpatient
- ☐ Psychologist
- ☐ Psychiatrist
- ☐ MFT
- ☐ LPCC
- ☐ LCSW
- ☐ Other:_____________________

Name of provider: ____________________________________How long?__________________

Reason for treatment: ______________________________Results:_________________________

Other information you think I should know: ____
____
____
____
____
____

Signatures:

I have answered these questions to the best of my knowledge.

Parent signature:____Date:_________________

Parent signature:____Date:_________________

© 2013 Richard S. Williams, LMFT and Associates. All rights reserved.