Richard S. Williams, LMFT
2020 Coffee Road, Suite H4
Modesto, CA 95355
(209) 985-7429

Client Information Sheet for Minors

☐ 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:_____

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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. _____

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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.

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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	☐ Group	☐ Psychologist	☐ LPCC
☐ Couple	☐ Outpatient	☐ Psychiatrist	☐ LCSW
☐ Family	☐ Inpatient	☐ MFT	☐ 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: _____