Confidential Client Information - Minor

Date: _____________

Welcome. Please fill out the following information about your child as completely and legibly as possible. If you have concerns about the relevance of any information and wish to leave it out, please feel free to do so. This information is confidential and will only be viewed by your child's psychologist.

Name: _________________________________ Age: __________
Birthdate: _______________ Birthplace: __________________
Address: ___________________________ City: _______________
Postal code: ________________ Phone: ______________________

Parent's name: ___________________________ permission to leave message?
Home phone: ________________________ ___ yes ___ no
Cell phone: __________________________ ___ yes ___ no
Email: ______________________________ may I contact you via email?* ___________
*please note that email is not considered to be a confidential medium of communication

Parent's name: ___________________q________ permission to leave message?
Home phone: ________________________ ___ yes ___ no
Cell phone: __________________________ ___ yes ___ no
Email: ______________________________ may I contact you via email?* ___________
*please note that email is not considered to be a confidential medium of communication

Non-parent Legal Guardian's name: ____________________________
relationship: _________________________ permission to leave message?
Home phone: ________________________ ___ yes ___ no
Cell phone: __________________________ ___ yes ___ no

Siblings (name & age): ____

In the case of parental separation, please indicate:
approximate date of separation. ____
living arrangements. ____
step parents. ____
step siblings. ____

Who will be responsible for making/keeping appointments? ________________________

Person to alert in the case of an emergency: _______________________________________
Relationship to the child: _____________________ Phone: _______________________

Current school & grade: ____
Attitude toward school: ____
Current academic functioning (please circle):
below grade level at grade level exceeding grade level

Please describe the concerns that have brought you here.

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Please indicate suspicions, if any, that you have regarding the nature of the concerns. (Ie. depression, anxiety, ADHD, learning disability, substance use, trauma, etc.)

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Please describe your child's past or present thoughts of wanting to hurt themselves or someone else.

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Please describe how your child handles stressors and copes with the concerns you have described.

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Please identify the name of any clinician(s) your child has seen in the past (psychiatrist, counsellor, etc.), dates of services, and the nature of the difficulty at the time.

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Please list any medications your child is taking, including prescription, over-the-counter medications or illicit drugs, as well as frequency and dose.

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Please describe any significant current or past medical problems (ie. asthma, allergies, diabetes, genetic disorders, etc).

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Please describe what you and your child hope to be able to achieve because of therapy.

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