MINOR CLIENT ASSESSMENT

Today's Date:_____

IDENTIFYING INFORMATION

Name: _____ D.O.B. ____/____/____ Gender _____

Place of birth _____ Ethnicity _____ Language preference _____

Home address _____

FAMILY INFORMATION

Names of both parents: A) _____ B) _____

Parent/Guardian (A) phone _____ email address _____

Parent/Guardian (B) phone _____ email address _____

Parental relationship status (*married, living together, separate)*: _____

If separated, **custody arrangement***: _____

Who are the adults in the home? _____ birth foster step adoptive

_____ birth foster step adoptive

Other children/siblings *(list names, ages, living situation)*:

_____

_____

Other adults in home: *(list name, relationship, time living in the home)*

_____

_____

Emergency contact name/Relation: _____ Phone: _____

THERAPY INFORMATION:

Who referred you? _____

Previous counseling:_____

Purpose for seeking therapy(*what support do you want for your child*?) _____

_____

PRESENTING CONCERNS

Please identify below any concerning symptoms or behavior in your child

Aggressive	Crying spells	Drug use	Hyperactive	Lying	School problems	Temper outbursts
Allergies	Dangerous behavior	Eating problems	Impulsive	Overeating	Self-harm	Trauma
Anger/Rage	Defiant	Family problems	Infantile	Nightmares	Sexual trouble	Truancy
Anxiety	Delayed response	Fearful	Irritable	Panic attacks	Shy	Unfocused
Appetite changes	Destructive	Gender Issues	Isolation	Peer problems	Sleep problems	Very unhappy
Asthma	Digestion problems	Grieving	Lacks motivation	Phobias	Stealing	
Bed wetting	Distractible	Headaches	Low energy	Restless	Stomachaches	
Clumsy	Domestic violence	Health problems	Low self esteem	Running away	Suicide behavior	

If other, please describe: _____

_____

HEALTH HISTORY *(birth experience, developmental milestones, current health, health changes, hospitalizations, etc.)*

Last physical/wellness visit: _____

_____

_____

_____

Current medication _____

Prescribing doctor _____

SCHOOL INFORMATION

Educational level _____ School _____

Academic performance _____

Peer relations in school _____

FAMILY AND COMMUNITY SUPPORTS

Are there people in your family or community that support your child? _____

Does your child receive support from religious or spiritual groups? _____

STRENGTHS:

Share your child's strengths and talents _____

_____

_____

Share your child's interests _____

_____

_____

What helps your child to continue during hard times? _____

_____

What resources does your child need to help with his/her goals? _____

_____

Clinical Notes/MSE: