Acct: ______________________
Rev: 09/19

Child/Adolescent Client Information

Name: ______________________ Age: ________ Birthdate: ______________

Address: ______________________

City: ______________________ State: ______________ Zip: ______________

School: ______________________ Grade: ______________

Mom/*Guardian Name: ______________________ Age: ________ Birthdate: ______________

Dad Name: ______________________ Age: ________ Birthdate: ______________

Mom Phone: ______________________ Dad Phone: ______________________

Home Phone: ______________________ Parent Email: ______________________

Person Responsible for Payment (if different): ______________________

Address: ______________________

City: ______________________ State: ______________ Zip: ______________

Home Phone: ______________________ Cell: ______________________

Work Phone: ______________________ Email: ______________________

How did you hear about New Beginnings Counseling Center (NBCC)? ______________________

Appointment Reminders and Additional Contact from NBCC: Currently, appointment reminders are made via phone. However, in the future, NBCC is considering automated appointment reminders. When this change is made, how would you (parent/guardian) like to receive appointment reminders? (Check ONE)

☐ Text to (Parent): ______________________ ☐ Email to (Parent): ______________________

☐ Continue calling me (Parent) at: ______________________

May your child's provider leave voicemails regarding session content and/or mental health information at the number provided for appointment reminders? (This includes return phone calls regarding questions you may have.) ☐ **Yes** ☐ **No**

Please Note: A 24-hour cancellation notice is required to avoid a possible cancellation fee.

Emergency Contact: ______________________ Relationship: ______________________

Address: ______________________ Phone: ______________

Primary Care Physician (PCP): ______________________

Address: ______________________

City: ______________________ State: ______________ Zip: ______________

Phone: ______________________ Fax: ______________________

Psychiatrist (if applicable): ______________________

Address: ______________________

City: ______________________ State: ______________ Zip: ______________

Phone: ______________________ Fax: ______________________

If your child is receiving testing services, to which of the above providers would you like the results sent? **To insure that results are sent as quickly as possible, please provide ALL contact information.**

☐ **Primary Care Physician** ☐ **Psychiatrist** ☐ **Both** ☐ **Neither** ☐ **N/A**

*Guardian: If the minor client lives with someone other than a parent, please note this and provide information accordingly.

Name: ______________________________

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Consent to Receive Services

A parent/guardian's signature below indicates the following:

- A copy of the NBCC Provider-Client Service Agreement and the NBCC Notice of Privacy Practices has been made available to you (parent/guardian).
- You (parent/guardian) consent to accept these policies as a condition of receiving mental health services.
- You (parent/guardian) consent to receive appointment reminders from NBCC.
- You (parent/guardian) consent to contact of the person you identified in an emergency.
- Any questions you (parent/guardian) have regarding this information have been addressed.
- You (parent/guardian) acknowledge your right to ask questions about these policies at any time.

______________________________________ ______________________________________

Signature of Parent/Guardian Date

____

Printed Name of Parent/Guardian

Name: ______________________

Acct: ______________

Personal and Family Information

What brings you to counseling today? ____

____

What are your goals for counseling? ____

____

Biological Parents' Marital Status

☐ Single ☐ Married ☐ Cohabitating ☐ Divorced ☐ Separated ☐ Widowed ☐ Other: _________

Length of marriage/relationship: ____________ If divorced, how old were you at the time? ___________

Household Information

Please provide the following information for each person currently living in your home. If you spend time in two homes, please describe both:

Name	Age	Relationship to Self

Legal Involvement (Client and/or parents)

Do you/parents have any current or expected legal involvement (including divorce and custody proceedings)? ☐ **Yes** ☐ **No** If yes, please explain: ______________________________

____

Are you/parents currently under an order of protection? ☐ **Yes** ☐ **No** If yes, please explain: _________

____

History of Mental Health Services

Have you received mental health services in the past? ☐ **Yes** ☐ **No**

If yes, services received: ☐ Counseling ☐ Assessment ☐ Psychiatric Care ☐ Hospitalization

Briefly describe your experience (including clinicians and diagnoses): ______________________________

____

Have you previously taken medications for mental health concerns? ☐ **Yes** ☐ **No**

If yes, please list medications, when taken, and reason no longer taking: ______________________________

____

Name: ___________________________

Acct: _______________

Psychological Concerns (check all that apply)

Feelings
- ☐ Tension
- ☐ Rage
- ☐ Low self-worth
- ☐ Dread
- ☐ Boredom
- ☐ Loneliness
- ☐ Guilt
- ☐ Anxiety/Panic
- ☐ Hopelessness
- ☐ Helplessness
- ☐ Worthlessness
- ☐ Depression
- ☐ Other: _______________

Thoughts
- ☐ Vivid Dreams/Nightmares
- ☐ Persecution
- ☐ Hearing Voices
- ☐ Seeing Visions
- ☐ Being out of Body
- ☐ Thoughts Confused/Controlled
- ☐ Racing Thoughts
- ☐ Obsessive Thoughts
- ☐ Suicidal Thoughts
- ☐ Homicidal Thoughts
- ☐ Other: _______________

Behaviors
- ☐ Self-Harm
- ☐ Anger Outbursts
- ☐ Eating Issues
- ☐ Spending Issues
- ☐ Stealing
- ☐ Gambling
- ☐ Poor Decision-Making
- ☐ Irresponsibility
- ☐ Obsessive/Compulsive Behaviors
- ☐ Impulsiveness
- ☐ Drug or Alcohol Use
- ☐ Other: _______________

Specific Fears
- ☐ Crowds
- ☐ Small Spaces
- ☐ Death
- ☐ Losing Control/Sanity
- ☐ Being Alone
- ☐ Other: _______________

Trauma History
- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Emotional Abuse
- ☐ Violent Crime
- ☐ Domestic Violence
- ☐ Witness Violent Crime/Death
- ☐ Other: _______________

Spiritual Concerns
- ☐ Alienated
- ☐ Uninvolved
- ☐ Doubt
- ☐ Other: _______________

Social and Occupational Concerns (Check all that apply)

Intimate Relationships
- ☐ Unfaithful Spouse/Infidelity
- ☐ Pregnancy before Marriage
- ☐ Fertility Issues
- ☐ Work Interference
- ☐ Conflict/Control Issues
- ☐ Sexual Issues
- ☐ Separation/Divorce
- ☐ Post-Divorce Issues
- ☐ Jealousy
- ☐ Other: _______________

Sexuality
- ☐ Identity Concerns
- ☐ Changed Desire
- ☐ Misconduct
- ☐ Impotence
- ☐ Fearful/Inhibited
- ☐ Addiction/Excess
- ☐ Other: _______________

Family
- ☐ Blended Family
- ☐ Custody Issues
- ☐ Conflict with In-Laws
- ☐ Domestic Violence
- ☐ Death
- ☐ Conflict/Fight
- ☐ Separation
- ☐ Illness
- ☐ Issues with Children
- ☐ Housing Issues
- ☐ Elderly Parents
- ☐ Other: _______________

Finances
- ☐ Debt
- ☐ Bankruptcy
- ☐ Bad Checks
- ☐ IRS Problems
- ☐ Other: _______________

Education/Occupation
- ☐ Lack of Career Direction
- ☐ Frequent Job Changes
- ☐ Poor Performance
- ☐ Dissatisfaction
- ☐ Harassment/Discrimination
- ☐ Lack of Education/Training
- ☐ Potential Job Loss
- ☐ Other: _______________

Leisure
- ☐ No Free Time
- ☐ No Outside Interests
- ☐ Boredom
- ☐ Lack of Enjoyment
- ☐ No Friends
- ☐ No Social Outlets
- ☐ Other: _______________

Name: ____________________

Acct: ____________

Physical Health Concerns (Check all that apply)

Changes In:
- ☐ Sleep Habits
- ☐ Appearance/Hygiene
- ☐ Energy Level
- ☐ Weight
- ☐ Other: ____________

Cardiac Health
- ☐ Shortness of Breath
- ☐ Heart Racing
- ☐ Rapid Breathing
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Arrhythmia
- ☐ Mitral Valve Prolapse
- ☐ Other: ____________

Digestive Health
- ☐ Nausea
- ☐ Vomiting
- ☐ Stomach Pain
- ☐ Diarrhea
- ☐ Ulcers
- ☐ Other: ____________

Neurological Health
- ☐ Attention/Focus Issues
- ☐ Memory Problems
- ☐ Headaches/Migraines
- ☐ Vision Problems
- ☐ Seizures
- ☐ Head Injury
- ☐ Confusion
- ☐ History of Concussion
- ☐ Speech Problems
- ☐ Balance/Coordination Issues
- ☐ Numbness/Tingling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Blackouts
- ☐ Tremors
- ☐ Other: ____________

Lung Health
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic Cough
- ☐ Other: ____________

Endocrine Health
- ☐ Diabetes
- ☐ Thyroid Issues
- ☐ Hormone-Related Issues
- ☐ Other: ____________

Muscle/Bone Health
- ☐ Chronic Pain
- ☐ Back Issues
- ☐ Weakness
- ☐ Other: ____________

Gynocological Health
- ☐ Menstrual Difficulties
- ☐ PMS Symptoms
- ☐ Miscarriage
- ☐ Endometriosis
- ☐ Hysterectomy
- ☐ Other: ____________

Other
- ☐ Skin Rash/Issues

Additional Health Information

☐ Cancer History: ____________ ☐ Surgeries: ____________

☐ Allergies: ____________ ☐ Other: ____________

How would you describe your overall health? ☐ Excellent ☐ Average ☐ Poor

Prescriptions, Over-the-Counter Medications, Herbs, and Supplements (Past 6 Months)

Name	Dose/Frequency	Condition Treated	Currently Using (Y/N)

Alcohol, Tobacco, Marijuana and Other Drugs

Substance	Amount/Frequency	Currently Using (Y/N)	Comments