Date: ____________________

Client Information Form Minor (18 below)

Please complete the following questions as best as possible. Your therapist will review your responses with you during your session. If you need assistance, please see the Front Office.

Notes:

- The completed form can either be brought to first session or emailed prior to info@fcs-midland.org
- Please bring your insurance card to your first session
- If you would like to apply for our sliding fee scale, you must also bring proof of household income (most recent pay stub, W-2 or Tax Returns) to the session.

Client Legal Name: **Preferred Name:**

Date of Birth: **Age:** **Sex:**

Preferred Pronoun: **he/his** **she/her** **they/their** **Other:**

Street Address: **City:**

Mailing Address: **Zip Code:**

May Letters Be Mailed to you? **Yes** **No**

Primary Phone Number: **Cell** **Landline**

May a detailed message be left? **Yes** **No**

Do you want phone appointment reminders? **Yes** **No**

Email Address:

Name of Person filling out this form:

Relationship to Client:

- Legal Mother's Name: Phone:
- Address:

May a detailed message be left? Yes No

- Legal Father's Name: Phone:
- Address:

May a detailed message be left? Yes No

- Guardian: Yes No Guardian Name:
- Address:
- Phone:

May a detailed message be left? Yes No

Date: ____________________

Emergency contact Person: Relationship:

Phone:

List person(s) authorized to make, change, or cancel appointments on Client's behalf:

Name: _________________________________ Name: _____________________________________

If parents are divorced, what is the current court ordered custody arrangement (Circle One):	
Sole Custody	**Joint-Legal**

Please list other Individuals living in Client's home:

Household #1 -Name	**Age**	**Relationship**

Household #2 -Name	**Age**	**Relationship**

1. Briefly explain your reason(s) for seeking services:

family & children's services

Date: ____________________

2. Has the Client ever experienced any of the following?

   Nightmares Bedwetting Sleepwalking Stuttering Thumb Sucking Nail Biting

   School Phobia Fire Setting Drugs/Alcohol Sexual Abuse Physical Abuse

   Witness to Abuse Verbal Abuse Self-Harm Behavior Neglect Not Applicable

   Other:

3. Does the Client have difficulty coping with any of the following?

   Change/New Situation Making friends Keeping Friends Losses Anger

   Expressing emotions Self-Esteem Other:

4. Does the Client currently attend school/college/vocational training: Yes No

Name of Teacher:

5. Do you have any concern about the Client's behavior in school with the following?

   Attendance Defiance Suspensions/Expulsions Fighting with Peers

   Fighting with Staff Academic Performance/Grades 504 Plan No Concerns

   Other/Explain:

Do you have and IEP or a 504 Plan? Yes No Please provide a copy of the Plan.

What support is received at School?

6. Has the Client been previously diagnosed with a Mental Health Disorder? Yes No Unsure

7. Has the Client ever had past treatment for?

   Substance Use Mental Health Both Substance Use/Mental Health

   No Past Treatment Unsure Date of Treatment:

8. Has the Client ever stayed in the hospital for mental health reasons? Yes No Unsure

   If yes when?

family & children's services

Date: ______________________

9. Have any of the Client's relatives experienced any of the following mental health disorders?

Disorder	Yes, No, or Unsure	Relative (Mother, Father, Grandparents, etc)
Anxiety		
Depressive		
Bi-Polar		
Psychotic		
Behavioral		
ADHD/ADD		
Substance use/abuse		
Mental Retardation		
Pervasive Development Disorder		
Eating Disorder		

Physical Health:

10. Does the Client use any alternative healthcare approaches? (check all that apply)

None Acupuncture Movement Therapies Dietary Supplements
Yoga Homeopathy Massage Therapy Relaxation techniques
Meditation Naturopathy Traditional Healers

11. Please check any current or past health conditions the Client has:

Allergies Diabetes Heart Disease Asthma Seizures
Head Injury Sleep problems Chronic Pain Headaches Hearing Issues
Vision Issues Kidney Disease Obesity Arthritis Cancer
Stroke High Cholesterol Stomach Pains High Blood Pressure None
Other Explain:

12. Does the Client have a Doctor? Yes Doctor Name: No
When was the last time the Client saw a Doctor?

13. Please list the Client's medications/dosage (Including Mental Health):

Name of Medication	Dosage	Frequency

family & children's services

Date: ____________________

14. What is the Client's current sleep patterns like (how many hours of sleep per night, trouble falling to sleep, trouble staying asleep, etc.)?

15. How is the Client's nutrition (number of meals per day, types of foods, unexpected weight loss/gain)?

16. Has the Client ever had surgery? Yes No Unsure
    If yes, What for:
    When:

17. Adoption Questions
    a. Is the Client adopted? Yes No
    b. Does the Client have a relationship with Birth parents? Yes No
    c. How many others are adopted in the home?

18. Was this a planned pregnancy? Yes No Unsure

19. Did the mother of the Client experience any circumstances that would have interfered with normal bonding when the Client was born? Yes No

    Please check all that apply?
    Premature Birth (how many weeks was mother pregnant?
    Client did not leave the hospital with mother Medical Problems at birth with Mother/Client
    Unsure Other:

    Please check any issues experienced while pregnant with Client:
    Drug Alcohol Tobacco Bleeding Infection Medical issue
    Mother did not receive regular Medical care while pregnant Unsure
    Other:

20. Did the Client have any problems after birth? Yes No Unsure
    Other:

family & children's services

Date: ____________________

21. How did the Client behave as an infant?

Happy	Playful	Irritable	Hard to Care for	Easy to care for
Active	Restless	Quiet	Liked to be held	Other:

22. Please describe any concerns about the Client's development in infancy and childhood (delays, trouble walking, or crawling, social issues, etc.):

23. How would you describe your parenting style?:

24. How would you describe your discipline style?:

25. Is the Client currently on Probation? Yes No Unsure
    If yes, Probation Officers name: How much longer?

26. Does the Client currently participate in any extracurricular activities? Yes No Unsure
    Describe:

27. Has the Client involvement in their hobbies/interests recently changed? Yes No Unsure

28. Has the Client participated in activities under the influence of drugs/alcohol? Yes No Unsure

29. Does the Client use social media? Yes No Unsure
    If yes, what types of social media are used?

30. Do you think the Client's use of social media is inappropriate? Yes No Unsure
    If so, in what way:

31. Does the Client currently have any spiritual beliefs? Yes No Unsure

32. Has the Client, in the past, had any spiritual beliefs? Yes No Unsure
    Explain:

family & children's services

Date: ____________________

33. Everyone has strengths like patience, education, a good home or other things that they can use to help them reach their goals. Some of the Client's strengths are:

Lively	Speaking	Fixed	Educated	Family Support	Happy	Busy
Funny	Free- Spirited	Bright	Musical	Strong	Creative	Independent
Helpful	Playful	Kind	Caring	Togetherness	Social	Supportive

34. No one's life is perfect and we might have needs that brought us to FCS or that make our live harder or keep us from reaching our goals. My Client needs are:

35. We all have abilities or special skills or talents like writing, arts, sports, or hobbies that we are good at doing. These can make our lives better. Some of the Client's talents or abilities are:

Sports	TV	Video Games	Outdoor activities	Reading
Walking	Running	Exercise	Scrapbooking	Dancing
Volunteering	Gardening	Hiking	Collecting	Art
Socializing	Music	None	Other:	

36. Having choices or preferences make changing or reaching goals a little easier. Choices could include things like when or where I have my appointments or whether I am part of a group or working with a counselor alone. My choices or preferences for the Client's treatment are:

37. Describe any other issues you would like to address:

- Can an Intern sit in on your Session? Yes No

family & children's services

Date: ______________________

(Optional/If Applicable)

Substance Use History Questionnaire

DRUG CATEGORY (Includes non-medical drug use)	Ever Used? (Yes/No)	Age of First Use	IV Use? (Yes/No)	Date Last Used (e.g. 2015)	Frequency of Use Past 6 months
ALCOHOL					
CANNABIS: Marijuana, Hash Oil, Pot, Weed					
STIMULANTS: Cocaine, Crack, Blow Methamphetamine – Meth, Ice, Crank					
AMPHETAMINES/OTHER STIMULANTS Ritalin, Benzedrine, Dexedrine, Speed, Bennies, Uppers					
BENZODIAZEPINES/ HYPNOTICS/ BARBITURATES: Vallum, Librium, Xanax. Diazepam, Roofies, Downers, Quaalude					
HERON: Smack, Scat, Brown Sugar, Dope					
STREET or ILLICIT METHADONE					
OTHER OPIOIDS: Tylenol #2 & #3, Percodan, Percocet, Morphine, Dilaudid					
HALLUCINOGENS: LSD, PCP, Mescaline, Peyote, Mushrooms, Ketamine, Ecstasy					
INHALANTS: Glue, Gasoline, Aerosols, Paint Thinner, Poppers, Rush, Whippets					
STEROIDS: Oxandrin, Steroids, Juice					
Non-Medical USE OF PRESCRIPTION DRUGS: ______________________________					
VAPING, SMOKING					
OTHER:					