Joyful Hearts Counseling

Client Information/Assessment Form

Client (child's) Name: _____Birth Date: ____ /____ /_____
(Last) (First) (M.I.)

Client Address:_____

City-State-Zip:_____

Telephone: (home)_____(cell)_____ May we leave a message? □Yes □No

E-mail address:_____ May we use to communicate? □Yes □No

Mother/guardian:

_____ Custody: □ Joint □ Full □ None
(Last) (First)

Address (if different):_____

City-State-Zip:_____

Telephone: (home)_____(cell)_____ May we leave a message? □Yes □No

E-mail address:_____ May we use to communicate? □Yes □No

Father/guardian:

_____ Custody: □ Joint □ Full □ None
(Last) (First)

Address (if different):_____

City-State-Zip:_____

Telephone: (home)_____(cell)_____ May we leave a message? □Yes □No

E-mail address:_____ May we use to communicate? □Yes □No

Best method of contact for appointment reminders? □text □e-mail □phone call □other_____

Client's School:

_____ Telephone:
_____

Place of Employment (client): Telephone:

_____ _____

Place of Employment (mother/guardian (minor client) Telephone:

_____ _____

Place of Employment (father/guardian (minor client) Telephone:

_____ _____

In Case of Emergency: Contact person: Telephone:

_____ _____

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Treatment History

Has your child previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes, previous therapist/practitioner:

_____

When and how long?

_____

Has your child ever been hospitalized for a psychiatric condition? □ No □ Yes
If yes, describe date(s) and circumstances:

_____

_____

Is your child currently taking any prescription medication? □ No □ Yes Please list with does:

_____

_____

If yes, who is your child's prescriber:_____

Has your child ever been prescribed psychiatric medication? □ No □ Yes
Please list and provide dates, along with the prescriber names:

_____

_____

General Health

1. How would you rate your child's current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific health problems your child is currently experiencing:

_____

_____

2. How would you rate your child's current sleeping habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific sleep problems your child is currently experiencing:

_____

_____

3. What types of physical activity does client participate in and how often?

_____

_____

4. Please list any difficulties your child experiences with appetite or eating patterns:

_____

_____

5. Please list any concerns with your child's developmental history or educational needs:

_____

_____

6. What kinds of hobbies or extracurricular activities does your child participate in?

_____

_____

Presenting Concerns

What would you like to see improve for your child during your time in therapy?-

_____

_____

Do you see any potential barriers to your child's participation in therapy?

_____

_____

Who do you consider to be your family's support system?

_____

_____

What do you consider to be some of your child's strengths?

_____

_____

Any other important information about your child to consider?

_____

_____