FAMILY COUNSELING CENTER ASSN.

MINOR

PATIENT NAME:_____ADDRESS:_____

CITY:_____STATE:____ZIP:_____SS#: no longer need

PHONE NUMBER: HOME:_____ CELL:_____

PERSONAL DATA

DATE TODAY:_____ REFERRED BY:_____

INDIVIDUAL DATA

SEX:____ DATE OF BIRTH:___/___/___ AGE:_____

EDUCATION COMPLETED (GRADES, DEGREES OR COURSES)_____

SCHOOL DATA

SCHOOL :_____PHONE:_____

PREVIOUS SCHOOL :_____PHONE:_____

PHYSICAL HEALTH DATA

VERY GOOD:_____GOOD:_____AVERAGE:_____POOR:_____

LIST PRESENT ILLNESSES, INCLUDING ALLERGIES:_____

WHEN WAS CHILD'S LAST MEDICAL CHECK UP? (DATE):_____

FINDINGS:_____

LIST OR DESCRIBE PURPOSE(S) OF MEDICATION OF ANY KIND NOW BEING TAKEN:_____

CHILD'S PHYSICIAN:_____

ADDRESS:_____

EMOTIONAL HEALTH DATA

HAVE YOU EVER HAD SERIOUS MENTAL DISTURBANCE OR A NERVOUS BREAKDOWN?_____IF SO, WHEN?_____

HAVE YOU HAD THERAPY BEFORE?_____ YES_____NO_____

WHEN?_____

WITH WHOM?_____

(Optional)

HAVE YOU EVER WITNESSED OR BEEN EXPOSED TO A TRAUMATIC EVENT?_____

(This includes witnessing an accident or death, being involved in a natural disasters--fire, flood, tornado, hurricane--or have you been the victim of abuse, sexual or otherwise.)

FAMILY STATUS

PARENTS LIVING? FATHER: _____YES _____NO ; MOTHER: _____YES _____NO

PARENTS: MARRIED_____SINGLE_____

WIDOWED_____IF SO, WHEN?____/___/____

DIVORCED_____IF SO, WHEN? ____/____/____

MARRIED WHEN?____/____/_____

HOW LONG DATING MATE?_____

SIBLINGS: AGE: DOB: COMMENTS: (STEP? OR HALF?)

_____

_____

_____

_____

_____