

Doorways, LLC

4747 N. 7th St., Suite 450, Phoenix, AZ 85014

Office: 602.997.2880 Fax: 623.399.4013

www.doorwaysarizona.com

New Client Information for Minors

Today's Date: _____ How did you find us? _____

I. Client Information

Legal Name: _____ Nickname: _____

Birth Date: _____ Age: _____ Social Security #: _____ Male Female

Address: _____ City: _____ State: _____ Zip: _____

How would you like us to contact you?

Phone _____ Voice Text (for automated reminders ONLY)

Email _____ Yes No

II. Family Information

The Minor's Biological/Adoptive Parents Are:	If Divorced, how is Custody Arranged?
<input type="checkbox"/> Never Married/Never Together	<input type="checkbox"/> Separated
<input type="checkbox"/> Living Together/Not Married	<input type="checkbox"/> Divorced
<input type="checkbox"/> Married	<input type="checkbox"/> Widowed
	<input type="checkbox"/> Sole – Mom
	<input type="checkbox"/> Sole – Dad
	<input type="checkbox"/> Joint
	<input type="checkbox"/> Guardian Appointed

(Circle one)

Biological/Adoptive Mother Name: _____ DOB: _____

Cell Phone: _____ Email: _____

Address: _____

Biological/Adoptive Father Name: _____ DOB: _____

Cell Phone: _____ Email: _____

Address: _____

Stepmother/ Guardian Name: _____ DOB: _____

Cell Phone: _____ Email: _____

Address: _____

If guardian, relationship to child: _____

Stepfather/ Guardian Name: _____ DOB: _____

Cell Phone: _____ Email: _____

Address: _____

If guardian, relationship to child: _____

Please complete this section for others residing in the client's primary residence:

Name	Date of Birth	Age	Relationship to Client	Gender	Relevant Medical History

III. Client Occupational/Educational Status

Currently employed? Yes No If yes, Full-Time Part-Time Occupation: _____

If you're not employed, please check any of the following Unemployed Student Other _____

If you're a student, please tell us which school you attend: _____

IV. Client's Health Status

Current or chronic medical issues: _____

Primary Care Provider: _____ Phone: _____

V. Client Background Information

*The following information is **optional** but will help us to better serve you.*

Marital Status

- Single Separated
- Living Together/Not Married Divorced
- Married Widowed

Sexual Orientation

- Heterosexual Transgendered
- Gay/Lesbian Not sure/questioning
- Bisexual

VI. Client's Medication History

Are you **currently** taking any medications for emotional/substance abuse problems? YES NO

Name:	Name:	Name:
Dose (mg):	Dose (mg):	Dose (mg):
Frequency:	Frequency:	Frequency:
Dates Used:	Dates Used:	Dates Used:

Have you **previously** taken any medications for emotional/substance abuse problems? YES NO

Name:	Name:	Name:
Dose (mg):	Dose (mg):	Dose (mg):
Frequency:	Frequency:	Frequency:
Dates Used:	Dates Used:	Dates Used:

Other medications: _____

Prescribing Provider: _____ Phone: _____

VII. Client's Mental Health History

Have you had prior mental health related services? YES NO

	Therapist Name/Facility	Phone #	Dates	Duration
Prior Therapy	1.	1.	1.	1.
	2.	2.	2.	2.
	3.	3.	3.	3.
Prior Hospitalization(s)	1.	1.	1.	1.
	2.	2.	2.	2.
	3.	3.	3.	3.

VIII. Presenting Problems/Life Stressors (please check all that apply):

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Abuse/trauma | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Recent loss/Death | <input type="checkbox"/> Weight loss or gain |
| <input type="checkbox"/> Alcohol/Drug abuse | <input type="checkbox"/> Legal problems | <input type="checkbox"/> Repeated | <input type="checkbox"/> Other |
| <input type="checkbox"/> Anger/Irritability | <input type="checkbox"/> Loss of job(s) | bothersome thoughts | _____ |
| <input type="checkbox"/> Anxiety/Stress | <input type="checkbox"/> Low self esteem | <input type="checkbox"/> Self-harm/Cutting | _____ |
| <input type="checkbox"/> Compulsive behaviors | <input type="checkbox"/> Medical/Physical | <input type="checkbox"/> Separations/Divorce | _____ |
| <input type="checkbox"/> Depression/Sadness | complaints | <input type="checkbox"/> Sleep difficulties | _____ |
| <input type="checkbox"/> Difficult relationships | <input type="checkbox"/> Memory difficulties | <input type="checkbox"/> Suicidal thoughts | _____ |
| <input type="checkbox"/> Eating/Food Issues | <input type="checkbox"/> Moves/Change of | <input type="checkbox"/> Trouble thinking/ | _____ |
| <input type="checkbox"/> Fears/Worries | school | Concentrating | |

Please briefly describe the reason for seeking counseling/psychiatric services at this time.
