Doorways, LLC

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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: _____

II. Family Information

The Minor's Biological/Adoptive Parents Are:		**If Divorced, how is Custody Arranged?**
☐Never Married/Never Together	☐Separated	☐Sole – Mom
☐Living Together/Not Married	☐Divorced	☐Sole – Dad
☐Married	☐Widowed	☐Joint
		☐Guardian Appointed

How would you like to receive your courtesy reminder? (please choose only one)

Guardian Name _____ ☐Email ☐Text Message ☐Voice Message

(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: _____

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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. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.
Prior Hospitalization(s)	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.

Have you had a previous mental health diagnosis? YES ☐ NO ☐

If *yes*, please list them below:

_____

_____

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

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

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

_____

_____

_____

_____

_____