

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 #: _____ Gender: Male Female Other _____

Preferred Pronoun if applicable: He/Him | Her/She | They/Them

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

II. Family Information (All parts required, if applicable)

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 Decision Making – Mom
	<input type="checkbox"/> Sole Decision Making – Dad
	<input type="checkbox"/> Joint Decision Making
	<input type="checkbox"/> Guardian Appointed

Biological/Adoptive Mother Name: _____ DOB: _____

Cell Phone: _____ Email: _____

Address: _____

Courtesy Reminder Status (Choose one): Email Text Message Voice Message

Biological/Adoptive Father Name: _____ DOB: _____

Cell Phone: _____ Email: _____

Address: _____

Courtesy Reminder Status (Choose one): Email Text Message Voice Message

Stepmother/Guardian Name: _____ DOB: _____

Cell Phone: _____ Email: _____

Address: _____

If guardian, relationship to child: _____

Courtesy Reminder Status (Choose one): Email Text Message Voice Message

Stepfather/Guardian Name: _____ DOB: _____

Cell Phone: _____ Email: _____

Address: _____

If guardian, relationship to child: _____

Courtesy Reminder Status (Choose one): Email Text Message Voice Message

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	
<input type="checkbox"/> Single	<input type="checkbox"/> Separated
<input type="checkbox"/> Living Together/Not Married	<input type="checkbox"/> Divorced
<input type="checkbox"/> Married	<input type="checkbox"/> Widowed

Sexual Orientation	
<input type="checkbox"/> Heterosexual	<input type="checkbox"/> Pansexual
<input type="checkbox"/> Gay/Lesbian	<input type="checkbox"/> Not sure/questioning
<input type="checkbox"/> Bisexual	<input type="checkbox"/> _____

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.

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):

- | | | | |
|--|--|--|--|
| <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.

VIII. Substance Use Assessment (please complete in full if applicable):

Please check any substances you have used (if applicable):

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Acid | <input type="checkbox"/> Heroin | <input type="checkbox"/> PCP |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Inhalants | <input type="checkbox"/> Prescription pills |
| <input type="checkbox"/> Cigarettes | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Other (i.e., cough med, herbal, salvia, etc.) |
| <input type="checkbox"/> Cocaine/Crack | <input type="checkbox"/> Meth/Crystal | _____ |
| <input type="checkbox"/> Ecstasy | <input type="checkbox"/> Mushrooms | |

Complete the following for any substances used more than 1 time:

Substance	Age 1 st Used	How long used	How Often	How Much	Last Time Used

- | | | |
|--|------------------------------|-----------------------------|
| 1. I use alcohol or drugs to get away from things that bother me. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. I use alcohol or drugs to solve my problems. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. I need more or stronger kinds of alcohol or drugs to produce the same feeling, I used to get. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Sometimes after using I forget what happened. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Sometimes I hide my drinking or drug using from others. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. I need alcohol or drugs to have fun. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Other people have complained about my drug use. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. I feel guilty about my drug or alcohol use. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. I feel bad about how my using hurts other people. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. I make promises to change and then fail to do so. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. I have made efforts in the past to change. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. I try to control my drug or alcohol use. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. I change jobs or relationships to make my life better. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. My drug or alcohol use has caused health, legal, work, or relationship problems in my life. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. I have experienced withdrawal symptoms. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. I've said or done things I wouldn't normally do when using drugs or alcohol. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 17. Drugs or alcohol have become a focus of my life. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Identify the response below that best represents your current level of willingness to change your substance use habits:

- I don't want to change
- Considering change
- Ready to change
- Making changes
- Changes have been maintained for 3 or more months