MINOR CLIENT INFORMATION SHEET

WELLSPRING COUNSELING CENTER
FIRST UNITED METHODIST CHURCH OF PLANO
3160 E. Spring Creek Parkway
Plano, Texas 75074
972-423-4506

Today's Date_____ Date of First Session (if different)_____

About the Minor
First Name_____MI_____Last Name_____

Prefers to be called_____ Date of Birth_____SS#_____

Gender M F Student Y N School_____Grade_____

Present Medications and Dosages:
_____
_____
_____

Physician:_____Phone:_____

Previous counseling? Y N If yes, where, when and with and with whom?
_____
_____

Faith Preference_____

If parents are divorced or if you are guardian for the minor, please supply us with a copy of the custody or guardianship agreement, as required by State law.

About You/Responsible Party
First Name_____MI_____ Last Name_____

Relationship to Minor_____

Address_____City_____State___Zip_____

Home Phone_____OK to leave message? _____

Cell Phone _____ OK to leave message?_____ OK to text?_____

Work Phone_____EXT_____ OK to leave message?_____

Email address_____

Your SS#_____ Employer_____

Any other adults entitled to discuss Minor's progress with Counselor:

Name_____
Phone_____email_____

Name_____
Phone_____email_____

Any Emergency Contact besides you:
Name_____ Phone_____
Relation to minor_____
In case of concern for the life and safety of the minor or of someone else, the minor's counselor may decide to notify the emergency contact person listed above. Your initials here indicate your understanding and acceptance of this. _____

How were your referred to the Center?_____
May we contact the person who referred you to thank them?_____

Personal Information about the Minor Child

What concerns about this minor child bring you to counseling at this time?
_____
_____
_____

Please rate the following behaviors from 1-5, where 1= Never and 5= Very Much

___Picks at self (hair, fingers, nails, clothing)
___Talks back to adults
___Problems making or keeping friends
___Excitable, impulsive
___Wants to run things
___Sucks or chews (thumb, clothing, hair, etc)
___Cries easily or often
___Carries a chip on his/her shoulder
___Daydreams
___Difficulty learning
___Restless or squirmy
___Fearful (of new situations, people, etc)
___Restless or always on the go
___Destructive
___Tells lies or stories that aren't true
___Shy
___Gets into trouble often
___Quarrelsome
___Denies mistakes or blames others
___Pouts or sulks
___Steals
___Disobedient or obeys resentfully
___Worries a lot
___Fails to finish things
___Feelings hurt easily
___Bullies others
___Unable to stop a repetitive activity
___Mean or cruel (to toys, animals, friends)
___Childish or immature
___Distractible or inattentive
___Headaches
___Mood swings
___Doesn't like or follow rules or restrictions
___Fights with siblings or other kids
___Easily frustrated in efforts
___Disturbs other children
___Basically unhappy
___Eating problems
___Sleeping problems
___Stomach aches

___Other aches and pains
___Boasts or brags
___Feels cheated in family circle
___Lets self be pushed around
___Bowel problems

Developmental History

Was pregnancy planned? Y N Or, is child adopted? Y N Age at adoption_____

Describe any complications during pregnancy or birth _____

_____

Any problems feeding? Y N Eating? Y N Sleeping? N Y

Describe, including Age and Duration _____

_____

Have there been any physical or emotional separations between child and care-taking adult durng first 26 months of life? Y N Describe_____
_____

Has this child been subjected to abuse by another person? Y N If yes, was it physical_____

emotional _____ sexual_____?

Age child: held head up____ turned over_____ sat_____ pulled up _____ smiled _____ crawled _____ walked with help_____ was weaned _____ used sentences _____ fed self _____ helped dress self _____ dresses alone _____ dry during day _____ dry during night _____

Is child: impulsive____ timid or shy____ stubborn____ clumsy____ well-coordinated____ affectionate_____?

Any special problem areas or history of particular stress for this child_____.

Why seeking counseling at this time?_____.

School Information
School_____District_____ Grade_____

Any special educational arrangements_____

Any specific concerns of teachers about this child_____

Does this child: get along well with teachers?_____ get along well with adults? _____ get along well with other students?_____ have difficulty making friends?_____ struggle with schoolwork?_____ work at grade level or above?_____

Other Information

Pediatrician_____ Office Phone_____ Fax_____
Email_____

List any medical problems or issues_____

List any medications this child is taking now_____

_____

Has this child seen a counselor or psychiatrist? Y__ N__

If Yes, when_____ Whom_____Phone_____

What do you like best about this child? _____

_____

Person completing form_____Relation to child_____

Signature_____ Date_____