The LifeWorks Group, P.A.
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WHO REFERRED YOU TO US? **TODAYS DATE:**

CHILD/ADOLESCENT CLIENT INFORMATION Date:

Child's Name: Date of Birth: Age:

Mother's Name: Father's Name:

Address: City, State, Zip:

Phone: (Home) (Work) (Cell) (Other)

Would you prefer to be contacted at ____ home ____ work ____ cell?

Email Adress: May we add you to our email list ___ Yes ___ No?

If parents are divorced, who has primary custody of this child?

Military Status of Mother and/or Father: ____ Active Duty _____ Veteren ____Retired

School: Grade:

Teacher:

Phone #:

Names & Ages of Siblings:

Religious Affiliation:

Name of Current Place Of Woship: Clergy's Name:

Address: Phone:

May we contact your place of worship about our services (counseling, groups, seminars, etc.)?

___ Yes but don't mention my name ___ Yes and you can mention my name ___ No way!

Who referred you, or suggested that you come to seek counseling? Check all that apply.

_____ Self _____ Parent _____ Friend _____ Employer _____ Other

Please summarize the issues for which you are seeking help. If there is more than one reason, rank them in order.

1)

2)

3)

Does anyone in your family suffer from alcoholism, an eating disorder, depression or anything that might be considered a mental health issue? Please explain.

MEDICAL/EMOTIONAL HISTORY

Physicians Name: Phone:

Date of last Physical:

Please list any prescription medications your child has taken within the last six months, circle current medications:

Has your child had any prior personal counseling? _____ Yes _____ No (If yes, please list therapists, dates, and addresses)

We are a training facility. Do you consent for a Masters Level Intern to observe your session? Yes____ No ____