

The Counseling Center at Davidson United Methodist Church  
Minor Client Information

Date of Initial Visit \_\_\_\_\_ Social Security # \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name of School Attending \_\_\_\_\_ Grade \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Mother's name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Father's name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

If parents are divorce or separated, please provide details about the custodial agreement: \_\_\_\_\_

List All Who Are Living in Household:

<u>Name</u>	<u>Relationship</u>	<u>Age</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Recent deaths of family/friends (Relation/dates) \_\_\_\_\_

List current illness(es) or symptoms \_\_\_\_\_

List any major surgeries, serious crises, losses, or handicaps (with dates) \_\_\_\_\_

Last Medical Exam \_\_\_\_\_ Reason \_\_\_\_\_

Name and Address of Physician \_\_\_\_\_

Current Medications Child/Adolescent is taking \_\_\_\_\_

Has your child/adolescent ever received psychotherapy, counseling, or other treatment for personal or family problems?

\_\_\_\_ Yes \_\_\_\_ No Dates \_\_\_\_\_

Name of Professional (Dr., agency, pastor, etc.) \_\_\_\_\_

Have you or any member of your family ever received or considered seeking help for drug or alcohol dependency?

\_\_\_\_ Yes \_\_\_\_ No Dates \_\_\_\_\_ Name of Professional/Agency \_\_\_\_\_

Substances Used \_\_\_\_\_

Who referred you to The Counseling Center? \_\_\_\_\_

Person Responsible for Payment \_\_\_\_\_

Type of Counseling: \_\_\_\_ Individual \_\_\_\_ Family \_\_\_\_ Group

Racial/Ethnic Identity: \_\_African-American \_\_Asian \_\_Caucasian \_\_Hispanic \_\_Native American \_\_Other \_\_\_\_\_

Religious Preference \_\_\_\_\_ Local Congregation \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

### **IMPORTANT QUESTIONS FOR YOU AND YOUR CHILD/ADOLESCENT'S COUNSELOR**

Please describe your reason(s) for seeking help \_\_\_\_\_

What would you like to have happen for you and/or your child/adolescent as a result of counseling? \_\_\_\_\_

#### FOR OFFICE USE ONLY

Counselor \_\_\_\_\_ Diagnosis \_\_\_\_\_ Agreed Upon Fee to be Paid by Client \_\_\_\_\_

Length of Visit \_\_\_\_ Half Hour \_\_\_\_ Hour \_\_\_\_ Hour and a Half \_\_\_\_ Two Hours