

Keira Oseroff, LCSW
Adolescent Client Information

Completion of this form is voluntary. You may leave any portion blank if you wish.

Name: _____ Referred By: _____

Street Address: _____

City/State/Zip _____

Telephone: Home: _____ Work: _____ Cell: _____

E-Mail Address: _____ Age: _____ Date of Birth: _____

Are your parents (circle) Married to each other Divorced Re-married

Who do you live with? _____

Brothers/Sisters ages: _____ Current school: _____

Grade: _____

Please tell me anything you think is important or that you want me to know about your family:

Mother:

Father:

Brother(s):

Sister(s):

Emergency Contact Information:

Name _____ Relationship: _____

Phone: _____ Alternate phone: _____

Have you ever been seen a counselor before? Yes _____ No _____

If yes, please say who you saw and for how long. Also, please explain how and why you ended therapy:

What brings you in for counseling? Please identify any issues or goals you would like to address while in therapy.

Are you currently under the care of a medical professional? Yes _____ No _____

If yes, who is your doctor/pediatrician? _____

Please list any prescription or non-prescription drugs you are currently taking and the doses if you know them:

Have you ever been hospitalized for psychiatric reasons? Yes _____ No _____ If yes, please state reason and dates of hospitalization. _____

Have you ever experienced suicidal or self harming thoughts or plans? Yes _____ No _____

If yes, please explain when and what the circumstances were:

Circle any of the following concerns that pertain to you.

Anxiety	Depression	Fears	Finances	Separation/Divorce/Relationships
Anger	Sleep	Drug Use	Alcohol Use	Loneliness
Concentration	Legal Issues	Pain	Eating/Food	School
Marriage	Losses	Spirituality	Health	Energy
Sexuality	Too Emotional	Family	Friends	Suicidal Thoughts
Sexual Abuse	Physical Abuse	Trauma	Communication	Other _____

Client Signature

Date