Client Background Information and Preferences for Children and Adolescents

Please know that the information you provide here is protected as confidential information. If you are unsure about a particular question, please leave it blank and we will discuss it later.

Child's Name: _____ Date: _____

Birth Date: _____ Age: _____ Gender: ☐ Male ☐ Female

Your Name: _____

Your Relationship to child: _____

Address to which Dr. Zook may send correspondence:

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone numbers at which Dr. Zook may reach you:

Home: _____ Is it ok to leave a message at this number? ☐ Yes ☐ No

Work: _____ Is it ok to leave a message at this number? ☐ Yes ☐ No

Cell: _____ Is it ok to leave a message at this number? ☐ Yes ☐ No

E-mail address to which correspondence may be sent: _____
*Please know that e-mail correspondence is not considered to be a trustworthy medium for confidential communication.

Emergency contact: _____ Phone: _____

Relationship to client: _____

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How did you hear about Dr. Zook? _____

How would you briefly describe the main issues for which you are seeking help for your child?

_____

_____

_____

On the scale below, please estimate the severity of these issues:

☐ Not a problem for my child, only for other people.

☐ Mildly upsetting to my child.

☐ Moderately upsetting to my child.

☐ Severely upsetting to my child.

☐ Extremely upsetting to my child.

When did these issues begin? _____

How have you tried to resolve these issues? _____

_____

_____

Are you currently working with another therapist? ☐ Yes,Name: _____

☐ No

Has your child previously received any kind of mental health services? ☐ Yes ☐ No

If so, please provide the following information regarding these services:

Name of therapist Dates of therapy Issue(s) treated

_____

_____

_____

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Has your child ever been prescribed psychiatric medication? ☐ Yes ☐ No

If so, please provide the following information regarding these medications:

Medication Name	Dose	Date Medication Started	Stopped Medication

Is your child currently taking any medication for physical concerns? ☐ Yes ☐ No

If so, please provide the following information regarding these medications:

Medication Name	Dose	Date Medication Started

Any significant physical medical conditions in the past or presently? ☐ Yes ☐ No

If so, please provide the following information regarding these conditions:

Medical Condition	Date of Onset

What is the date of your child's last physical examination? _____

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How many times a week does your child exercise or is physically active in some way? _____

How would you rate your child's sleep each night? ☐ Poor ☐ Good ☐ Excellent

Has your child ever been treated in a psychiatric hospital or in-patient setting? ☐ Yes ☐ No

Has anyone in your family ever:

Suffered from depression? ☐ Yes, relation to child: _____
☐ No

Been diagnosed with bipolar disorder? ☐ Yes, relation to child: _____
☐ No

Threatened to commit suicide? ☐ Yes, relation to child: _____
☐ No

Committed suicide? ☐ Yes, relation to child: _____
☐ No

Had problems with drugs or alcohol? ☐ Yes, relation to child: _____
☐ No

Been diagnosed with schizophrenia? ☐ Yes, relation to child: _____
☐ No

Suffered from panic attacks? ☐ Yes, relation to child: _____
☐ No

Suffered from an eating disorder? ☐ Yes, relation to child: _____
☐ No

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