CHILDREN'S Client Information Form for Office of Gary Mayne, M.A. LMHCA

Today's Date: ______________________________

Note: If your child has been a client of Gary Mayne before, please fill in only the information that has changed.

A. Identification - Insurance

Child's name: __________________________ Date of Birth: _______________ Age ________________

Resides with Mother/Father____
Home address ____

City: __________________________ Zip: _________________ Social Security #____________________

Parent's E-mail:__________________ Home/evening phone: _____________, Cell _________________

Parent's names/phone numbers – Mother: _____________________ Phones_____________________

Father: _____________________ Phones ____

B. Referral: Who recommended that you call this office?

Name: ____Phone: _________________________________

Full Address: ____

May I have your permission to contact this person and acknowledge the referral?
Yes ___ No ___

C. Your child's medical care: From whom or where does your child receive medical care?

Clinic/doctor's name: _______________________________ Phone/Fax: __________________________

Full Address: ____

If your child enters treatment with me, may I tell your medical doctor so that he or she is aware that your child is receiving services from me? Yes___ No___

D. Parent's employer

Mother's Employer: ________________________________ job title: ___________________________

City:_____________________________Work Phone: _____________________ Calls will be discreet, but

please indicate any restrictions:

Father's Employer _________________________________job title ____________________________

City: ____________________________Work Phone: ______________________Restrictions about calling?

E. School

Your child's grade _______ Please list your child's school and teacher(s)
____

Academic concerns:
____

Academic strengths:
____

Is child involved in sports?
____

F. Child's family-of-origin history

Relative	Name	Current age (or age at death)	Illness (or cause of death if deceased)	Education	Occupation

Father:____

Mother:____

Stepparents:____

____

Mother's
parents:____
____

Father's
parents:____

Brothers:

Sisters:

Step siblings: ____

____

G. Chief concern

Please describe the main difficulty that has brought you to see me:

____

1.Has your child ever received psychological or psychiatric or counseling services before?
Yes ___No ___ If yes, please indicate:

When? From whom? For what? With what results?

____

____

____

____

____

____

2. Do you the parent have now or or have you ever taken medications for psychiatric or emotional problems? Yes ____ No____

When? Which medications? For what? With what results?

____

____

____

____

I. Relationships in your family-of-origin. Please describe the following:

1. As parents, your relationship with each other:

____

____

2. Child's relationship with each parent and with other adults present:

____

____

______________, ______________, ______________

3. As parents, your physical health problems, chemical use, and mental or emotional difficulties:

____

____

4. Your child's relationship with your brothers and/or sisters, in the past and present:

____

____

5. How would you describe your child's childhood?

____

____

6. Who is he/she able to share very personal problems with?

J. Other. Is there anything else that is important for me as your child's therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:

K. Your Child's Medical History

1. Please list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, head injuries, convulsions/seizures, and any other medical conditions your child has had. Use an additional page if needed.

Age Illness/diagnosis Treatment received Treated by Result

2. List all medications or drugs your child takes now or in the last year

Medication/drug	Dose (how much?)	Taken for	Prescribed and supervised by

L. Medical caregivers

1. Your current family or personal physician or medical agency:

Name	Specialty	Address	Phone #	Date of last visit

2. Other physicians treating your child at present or in last 5 years:

Name	Specialty	Address	Phone #	Date of last visit

M. Health Habits

1. Exercise:

____

____

2. Food/eating concerns (i.e. over or under weight)

____

___

3. Do you try to restrict your eating in any way? How? Why?

___

___

4. Do you have any problems getting enough sleep?

___

___

N. Other

Are there any other medical or physical problems you are concerned about?

___

___

___

___

___

___

___

O. Legal History

1. Are you presently involved in a legal proceeding regarding your child or planning to initiate one?
Yes ___No___
If yes, please explain:

___

2. Is your reason for bring your child to me related to an accident or injury? Yes ___No___

3. Are you required by court, the police, or a caseworker or GAL to have this appointment?
Yes ___No___ If yes, please explain:

____

____

4. Attorney's name, if applicable: _________________________Phone:____________________

5. Are there any other legal involvements for yo as a parent I should know about?

____

____

____

U. Spiritual

1. Do you and/or your child currently attend a group with shared spiritual interests? If so, which one?
____

____

2. Does this spiritual community offer resources or meet needs for you and/or your child somehow?
____

____