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# CLIENT INFORMATION FORM – ADOLESCENT

**PLEASE USE BLACK OR BLUE INK**

## GENERAL INFORMATION

Today's Date _____

Client's Name _____ Referred by _____

Address _____City/State _____ Zip _____ Home Phone (  ) _____

Client Cell Phone (  ) _____ Client e-mail address: _____

Birthdate _____ Age _____ Gender Identity _____ Pronouns Used _____

Parent/Guardian Name _____ Occupation _____ Employer _____

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Parents' Cell Phones _____ Parents' emails _____

## SCHOOL INFORMATION (Child/Adolescent)

Name of minor's school _____ City _____Phone (  ) _____

Grade ____ School Counselor _____ Grades in current classes _____

Favorite Subjects _____ Least Favorite _____

Extracurricular Activities _____

## PERSONAL / FAMILY INFORMATION

Parents' Marital Status _____

If divorced or not with parent, who has legal custody? _____ physical custody? _____

what is visitation arrangement? _____ Names/ages of siblings _____

Emergency Contact: Name _____ Relationship _____ Phone(s) (  ) _____

Pregnancy and Birth History: Full Term _____ Premature _____ Adopted _____

Any unusual circumstances or difficulties with the pregnancy or post-partum? _____

## FINANCIAL INFORMATION

Preferred Payment: ___ Zelle (payable to DrJ@DrJJaffe.com) ___ Credit Card (Uploaded to Client Portal)

**(Credit Card Billing will appear as THERAPY PARTNER)**

**OVER**

**CONFIDENTIAL INFORMATION (if age 12 or older, will be shared with parent ONLY if life-threatening)**

Are you CURRENTLY seeing another psychotherapist or counselor? ____ If so: Phone (  ) _____

Name _____ For how long? _____ For what purpose(s)? _____

Have you PREVIOUSLY been in psychotherapy or counseling? ____ When? _____ For how long? _____

For what purpose(s)? _____What worked/did not work for you in that therapy?_____

Purpose for today's consultation: _____

_____ Learning disabilities/academic problems? _____

_____ Alcohol, drug, or tobacco dependence or frequent use? _____

_____ Eating disorder or Medical Problem? _____

_____ Legal problems? _____

_____ Self-injury or other addictive or compulsive behavior(s)? _____

_____ Depression or suicidal thoughts/attempts? _____

_____ Anxiety or panic attacks? _____

_____ Anger, arguments, domestic violence? _____

_____ Problems with boy/girlfriends or sexual matters? _____

_____ Other? _____

Please list stressful situations in your history (accident, hospitalization, separation from loved ones, traumatic event, etc.)
_____

What have you found has been helpful to you when you have felt depressed, anxious, etc.?
_____

**MEDICATIONS AND MEDICAL HISTORY**

Please list ALL prescription medications you are CURRENTLY taking:
_____

Please list any PREVIOUS medications you have taken for psychological purposes:
_____

How much/how often do you:

smoke cigarettes/vape _____ drink alcohol _____ drink caffeine (coffee/cola/chocolate) _____

use any other drugs (marijuana, cocaine, ecstasy, etc) _____

Date of last medical exam _____ Doctor's Name _____ Phone (  )_____

Other physical or medical conditions: _____

Tell me something else about you: _____