BTCONCEPTS

Client Information Form

Date: _____

Name of Client: _____ **DOB:** _____ **Age:** _____ **Sex** _____ **Race** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____

Emergency Contact _____ **Daytime Phone:** _____

Relationship to Client: _____

Please note that your therapist will contact this person in case of emergency

Preferred method of contact for scheduling changes, etc.:

☐ **Phone** ☐ **Email** ☐ **Text** ☐ **Other:** _____

REASONS FOR THERAPY:

- ☐ **Behavior/Conduct Challenges**
- ☐ **Emotional/Mental Illness**
- ☐ **Legal/Incarceration**
- ☐ **Lack of Medication Compliance**
- ☐ **Physical/Emotional Abuse**
- ☐ **Relational Conflicts**
- ☐ **Sexual Abuse**
- ☐ **School-Related Issue**
- ☐ **Social/Interpersonal Difficulty**
- ☐ **Substance Abuse**
- ☐ **Suicidality/Homicidality**
- ☐ **Work-Related Issues**
- ☐ **Other:** _____

PRESENTING SYMPTOMS (CURRENT OR PAST [within 30 days]):

- ☐ **Anxiety/Panic**
- ☐ **Attachment Problems**
- ☐ **Bedwetting/Soiling**
- ☐ **Bullying (Perpetrator/Victim)**
- ☐ **Cruelty toward Animals**
- ☐ **Depressed Mood**
- ☐ **Difficulty w/ Authority Figures**
- ☐ **Fire-setting**
- ☐ **Gang activity**
- ☐ **Homicidal Ideation, Intent, or Plan**
- ☐ **Hopeless/Helpless**
- ☐ **Hyperactivity**
- ☐ **Impulsivity**
- ☐ **Irritability**
- ☐ **Lying/Manipulative**
- ☐ **Obsessions/Compulsions**
- ☐ **Oppositional Defiant**
- ☐ **Peer Conflict**
- ☐ **Physical Aggression e.g. fighting**
- ☐ **Property Destruction**
- ☐ **Running Away**
- ☐ **School-related issues**
- ☐ **Self-injurious behavior**
- ☐ **Separation Difficulty**
- ☐ **Severe Sibling Rivalry**
- ☐ **Sexually Inappropriate Behavior**
- ☐ **Sleeping issues**
- ☐ **Social Withdrawal**
- ☐ **Stealing/Theft**
- ☐ **Substance Use Issues**
- ☐ **Suicidal Ideation, intent, or Plan**
- ☐ **Trauma-Related**
- ☐ **Tantrums/Outbursts**
- ☐ **Truancy from School**
- ☐ **Verbal Aggression e.g. cursing**
- ☐ **Other:** _____

In need of urgent care? **Select all that apply:**

☐ **Suicide Risk** ☐ **Danger to self or others** ☐ **Urgent/Critical Medical Condition**
☐ **Immediate Threat** ☐ **Past Psychiatric Admission (e.g., date of last admission, :** _____

As a result of the above selected behaviors, the minor experiences disruptive functioning in one or more life domains:

☐ **Home** ☐ **School/Work** ☐ **Family Life** ☐ **Social Life** ☐ **Community**

Have you ever participated in therapy before? ☐ **Yes** ☐ **No**
Therapist Name: _____ **Agency:** _____
Work Phone: _____ **Fax Number:** _____

Frequency of Therapy: ☐ **Weekly** ☐ **Bi-weekly** ☐ **Monthly** ☐ **Other:** _____

Type of Therapy: ☐ **Individual** ☐ **Family** ☐ **Group** ☐ **Other:** _____

Is client currently receiving pharmacological treatment? ☐ **Yes** ☐ **No**
If yes, please list client's medication(s):
Type: _____ **Dosage:**_____ **Frequency:** _____

Type: _____ Dosage:_____ Frequency: _____
Type: _____ Dosage:_____ Frequency: _____

Frequency of Medication Management Appointments: ___ Weekly ___Bi-weekly ___Monthly ___Other: _____

Is client medication compliant? ___ Yes ___ No

Expectations:
What would you like to achieve from therapy?
_____
_____

How long have your current stressor(s) been occurring? _____

What has helped to alleviate current feelings? _____