

Affinity Counseling Center, LLC

Client Information (Under 18)

Name of Child: _____ DOB: ____/____/____ Age: _____

Address: _____

City, State, Zip Code _____

School: _____ Grade: _____ Ever held back/grade _____

Please indicate which of the numbers you provide below is the best for us to call to leave messages regarding your appointments: _____

Home: _____ Work: _____ Cell: _____

Email address: _____ Ok to email you _____

Family Information (indicate who child lives with):

Mother's Name: _____ Mother's Cell phone: _____

Father's Name: _____ Father's Cell phone: _____

Stepmother's name: _____ Stepfather's name: _____

Parent email address: _____ Ok to email you _____

Siblings to child:

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Insurance Information (if applicable):

Insurance Company: _____

Insurance Policy Number/Group Number: _____ Start Date: _____

Responsible Party: _____ Employer: _____

Who referred you to this office _____

Physician: _____

Current medications/herbs/vitamins: _____

Any serious medical conditions: _____

Previous Psychiatric Treatment (practitioner, year, type of treatment, and medication): _____

Current Stresses: _____

Reason for seeing therapist (major problem): _____

Please indicate if any of these symptoms have been present in the past 3 months

Depressed mood		Sleep disturbance	
Loss of interest		Panic attacks	
Loss of pleasure		Excessive muscle tension	
Excessive fatigue		Excessive nervousness	
Loss of appetite		Difficulty breathing/smothering	
Thoughts of self harm		Feeling very slowed down	
Thoughts of harming others		Acting out behaviors	
Trouble concentrating		Doing poorly in school	
Weight gain		Defiance/rebellion	
Weight loss		Change in behavior	
Agitation		Poor relationship skills	
Feelings of unreality		Fear of losing control	
Inappropriate elation		Hallucinations (seeing or hearing things)	
Inappropriate irritability		Suspiciousness of several people	
Grandiose notions		Overly rapid/Skipping heartbeat	
Increased pressured speech		Difficulty remembering/Mind going blank	
Disconnected, racing thoughts		Unwanted recurrent persistent thoughts	
Markedly increased energy		Repetitive behavior or mental acts that you feel driven to perform	
Distractibility		Behaviors or thoughts aimed at warding off some dreaded event	
Impulse control problem		Confusion	
Low self-esteem		Wide mood swings	
Nervous habits			
Social withdrawal			