STEPHANIE COKER, LCSW, LCDC, CDWF
COKER COUNSELING AND LIFE COACHING, PLLC
860 HEBRON PKWY., STE 803, LEWISVILLE, TX 75057 - 972.318.9272

Adolescent Client Information
to be completed by parents

CHILD'S NAME: _____ GENDER:_____ DOB: _____ AGE: _____

CONTACT INFORMATION FOR GUARDIAN:
NAME: _____ GENDER:_____ DOB: _____
Type: ____ Mother_____ Father ____ StepMother ____ StepFather ____ Grandparent
ADDRESS: _____ CITY:_____ ZIP: _____
E-MAIL ADDRESS(ES):_____ Okay to get email at this address? Y / N
HOME PH: _____ WORK PH:_____ CELL PH:_____
BEST NUMBER TO CONTACT YOU?_____Okay to text and leave voice mail at this number? Y / N
SOCIAL SECURITY #_____ DRIVER'S LIC. #_____
SINGLE: ____ MARRIED:____ DIVORCED:____ WIDOWED:____
OCCUPATION:_____ EMPLOYER: _____

DOES CHILD LIVE WITH BOTH PARENTS/GUARDIANS? _____ Y _____ N

IF **YES:**
CONACT INFORMATION FOR OTHER PARENT/GUARDIAN:
NAME: _____ GENDER:_____ DOB: _____
Type: ____ Mother_____ Father ____ StepMother ____ StepFather ____ Grandparent
E-MAIL ADDRESS(ES):_____ Okay to get email at this address? Y / N
WORK PH:_____ CELL PH:_____
BEST NUMBER TO CONTACT?_____ Okay to text and leave voice mail at this number? Y / N
SOCIAL SECURITY #_____ DRIVER'S LIC. #_____
OCCUPATION:_____ EMPLOYER: _____

IF **NO:**
DO PARENTS SHARE MEDICAL DECISIONS? _____Y _____N
IF NO, WHICH PARENT HAS THE RIGHT TO MAKE DECISIONS ABOUT MEDICAL CARE?
_____
Are you currently separated, in the process of divorce or any dispute over custody or child support? _____ Y _____ N
IF YES, EXPLAIN: _____

CONTACT INFORMATION FOR NON-CUSTODIAL PARENT:
NAME: _____ GENDER:_____ DOB: _____
Type: ____ Mother_____ Father ____ StepMother ____ StepFather ____ Grandparent
ADDRESS: _____ CITY:_____ ZIP: _____
E-MAIL ADDRESS(ES):_____ Okay to get email at this address? Y / N
HOME PH: _____WORK PH:_____ CELL PH:_____
BEST NUMBER TO CONTACT?_____ Okay to text and leave voice mail at this number? Y / N
SOCIAL SECURITY #_____ DRIVER'S LIC. #_____
SINGLE: ____ MARRIED:____ DIVORCED:____ WIDOWED:____
OCCUPATION:_____ EMPLOYER: _____

CHILD'S CONTACT INFORMATION (IF APPLICABLE):
CELL: _____ EMAIL: _____
INDICATE PERMISSION FOR WHICH OF THE FOLLOWING: ____ Text _____ Voicemail ____ Email

REFERRAL SOURCE: _____

ANY OTHER MEDICAL PROFESSIONALS CHILD IS CURRENTLY SEEING (name, type of professional and phone number):
_____

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Presenting Information

What are the main problems that caused you to seek help for your child at this time?

_____

_____

When did these problems first begin?

_____

_____

Please check the statement below that best describes the course of these problems since they began:
___The problems have stayed about the same since they started.
___The problems have steadily worsened since they started.
___The problems come and go; by the time my child feels almost back to their usual self, the problems come back.
___The problems have ups and downs but haven't gone away completely since they started.

Has there been a time in the past when your child has had similar problems? If so, when?

_____

_____

Below are listed several areas of functioning. Please check any areas that have become worse for your child.

___ School performance
___ Relationships with family
___ Interest in keeping up appearance
___ Ability to control behavior (acting before thinking)
___ Relationships with peers
___ Ability to manage usual chores at home
___ Ability to control temper
___ Ability to enjoy usual interests/hobbies

Any other concerns about functioning? If so, please explain_____

Psychiatric History

Has your child ever received counseling? _____ Y _____ N
If yes, please explain: _____

Has your child had psychological testing in the past? _____ Y _____ N
If yes, date of testing: _____ Name and organization: _____
What was the diagnosis/conclusion of testing? _____
Can you provide a copy of results? _____ Y _____ N

Has your family ever participated in family therapy on behalf of this child or family member? ____ Yes _____ No
If yes, please explain: _____

Has your child ever attempted suicide? ____Yes ____ No
If yes, please state when and what type of treatment(s) experienced:_____
_____

Has your child ever thought of hurting and/or killing him/herself? ____Yes ____ No
If yes, please explain:_____

Has your child ever thought of hurting and/or killing someone else? ____Yes ____ No
If yes, please explain:_____

Has your child ever participated in self harming behavior? ____ Yes _____ No
If yes, please explain:_____

Has your child ever had difficulty with eating habits, such as binge eating or purging? ___ Yes ___ No
If yes, please explain:_____

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Has your child ever had hallucinations, such as hearing voices or seeing things? ____Yes ____ No
If yes, please explain:_____

Has your child ever engaged in starting fires or cruelty to animals? _____ Yes _____ No
If yes, please explain:_____

Has your child ever experienced a traumatic event that resulted in nightmares and/or flashbacks? ____Yes ____ No
If yes, please explain:_____

Past Treatment History - Please list any previous psychiatrists, psychologists, therapists or programs:

Name of Person Seen	Dates Seen (mo/yr-mo/yr)	Medications Prescribed	Reasons Seen	Hospitalized? (Yes/No? Where)
1.				
2.				
3.				
4.				

Family History

List any blood-relatives (parents, siblings, grandparents, aunts, uncles, cousins, etc.) of the child who have any history of any emotional problems (depression, manic-depression, anxiety, schizophrenia, drug/alcohol abuse, suicide attempts, etc.), whether known or suspected.

Relation (Father, Aunt, Daughter, etc.)	Father/Mother's Side of Family?	Problem (Depression, Alcoholism, etc.)	Ever Hospitalized? (Yes/No)	Medications Taken (If known)
1.				
2.				
3.				
4.				

Substance Use

Has your child ever had treatment for substance use? _____Yes _____No
If yes, when and where _____

Does your child smoke cigarettes or use any tobacco products? _____YES _____ NO
If yes, what and how often? _____ Intending to quit soon? _____YES _____ NO

Do you suspect your child may be experimenting with drugs or alcohol? _____ Yes _____ No
If yes, please explain _____

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Medical History

Who is your family or "main" doctor/Pediatrician? _____
When was your child's last appointment?_____ When was the last lab work?_____
Are there any medical procedures or chronic medical conditions your child has experienced? If so, please explain:
_____

Current Medications:

Medication	Dose (mg)	Times per day	When began? (mo/yr)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

* **Please list any medication allergies:**
_____

Past Psychiatric Medications - Please list any medications previously taken on a regular basis but not taking now:

Medication	Dose (mg)	Times per day	When began? (mo/yr)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Educational History

What grade is your child currently in? _____ What school? _____
Overall academic performance? _____
Any learning disabilities? _____
Any problems with truancy or school suspension? _____
Does your child feel school is a safe place? _____
Any problems with school anxiety? _____

Spiritual History

Does your child currently attend a church or other spiritual organization?___Y ___ N If yes, where?_____
How often?_____ Child's preferred religious practice? _____
Does this differ from the family's/parents religious practice? _____
How comfortable is your child with incorporating Spirituality into treatment?_____

Social & Family History

Was your child adopted? _____ If so, was it a closed or open adoption? _____
Any problems or complications with the child's birth or delivery that you are aware of?_____
Any issues with early development (talking, walking, toilet training, feeding, etc.)? _____
Generally, describe the relationship with each parent:_____
_____
Name, Age and Gender of Siblings currently in the home:_____
Name, Age and Gender of Siblings not currently living at home: _____
Generally, describe the relationships with each sibling: _____
_____
If parents are divorced, what age was child at the time of divorce? _____
If applicable, briefly describe child's response to the divorce: _____
How does your child respond to authority (teachers, coaches, etc.)? _____
Is your child currently dating?_____ If yes, name and age of significant other: _____
Is your child sexually active? _____ Does your child struggle with sexuality? _____

Occupational History

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Does your child currently work? ___Y ____N
How long in present position?_____ Employer? _____ Position? _____
Hours per week? _____ Job performance? _____

Legal Information

Has your child ever been warned, ticketed, or charged with MIP/DUI/DWI, public intoxication or other substance related offense? ____Y ___ N
If yes, list each offense, date, charge and result: _____
Ever on probation? ____ Y ____ N If yes, When? _____ For what offense? _____
Currently on Probation? _____ Y _____ N If yes, please explain: _____

Has your child ever reported abuse (physical or sexual) to you or any other adult? _____Y _____ N
If yes, please explain: _____

Grief, Loss & Stressors

Has anyone close to your child passed away in the last year?_____

Has anyone close to your child passed away prior to the last year, and if so, what age was your child?
_____
Any significant losses for your child in the past? _____
Any close friends who have died or committed suicide? _____

Any significant stressors or changes in the past year? (break up, moving, new job, starting new school, parents divorce or remarriage, injuries, etc.): _____
_____