



INSTRUCTIONS FOR NEW CLIENT PAPERWORK

CHILDREN OR TEENAGERS

- Parents**
Please complete all paperwork found under **New Client Paperwork – Adults** about yourselves.

- Child or Teenage Client**
Please complete the **Personal Data Inventory for Children or Teenagers** (*Form PSCC-C107*) that follows.

Form PSCC-C107

PERSONAL DATA INVENTORY FOR CHILDREN OR TEENAGERS

Please be sure to complete both sides.

YOUR NAME _____ TODAY'S DATE _____

ADDRESS _____

CITY, STATE ZIP _____ PHONE _____

WHAT SCHOOL DO YOU GO TO? _____ WHAT GRADE ARE YOU IN? _____

YOUR BIRTH DATE ____/____/____ WHERE WERE YOU BORN? _____

SEX (Circle one) M F AGE _____ HEIGHT _____ WEIGHT _____

RACIAL/ETHNIC IDENTITY: AFRICAN-AMERICAN ASIAN CAUCASIAN
 LATINO NATIVE AMERICAN
 OTHER _____

RELIGIOUS HISTORY:

WHAT DENOMINATION OR RELIGION IS YOUR FAMILY? _____

WHICH CHURCH? _____ PASTOR'S NAME _____

HOW MANY TIMES PER MONTH DO YOU USUALLY ATTEND SERVICES? (Circle one) 0 1 2 3 4 5+

DO YOU FEEL COMFORTABLE TALKING TO YOUR PASTOR ABOUT PERSONAL MATTERS? YES NO

DOES YOUR PASTOR KNOW ABOUT THE PROBLEM THAT BRINGS YOU TO COUNSELING? YES NO

HAVE YOU BEEN BAPTIZED? YES NO NOT SURE CONFIRMED OR JOINED CHURCH? YES NO

DO YOU BELIEVE IN GOD? YES NO NOT SURE

DO YOU PRAY TO GOD? NEVER SOME OFTEN

DO YOU PARTICIPATE IN A YOUTH GROUP? YES NO SOMETIMES

HAVE YOU EVER FELT TREATED BADLY BY A PASTOR OR OTHER RELIGIOUS LEADER? YES NO

HAS ANY OF YOUR FRIENDS, RELATIVES, OR PETS DIED? PLEASE LIST NAMES AND DATES.

HAVE YOU EVER OR ARE YOU CURRENTLY EXPERIENCING ANY FORM OF SEXUAL ABUSE? YES NO

HAVE YOU EVER BEEN OR ARE YOU CURRENTLY IN A DOMESTIC VIOLENCE SITUATION? YES NO

DO YOU FEEL SAFE IN YOUR CURRENT LIVING SITUATION? YES NO

IS THERE ANYTHING ELSE THAT WOULD BE HELPFUL FOR YOUR THERAPIST TO KNOW?

MEDICAL INFORMATION:

RATE YOUR PHYSICAL HEALTH: *(Circle one)* VERY GOOD GOOD AVERAGE DECLINING POOR

RECENT WEIGHT CHANGE: LOST _____ LBS. GAINED _____ LBS. NEITHER

HAVE YOU BEEN SERIOUSLY SICK OR HURT, OR DO YOU HAVE A CHRONIC HEALTH PROBLEM?

(Please mention any time you were in the hospital.)

DATE OF LAST MEDICAL EXAMINATION: _____ DOCTOR'S NAME: _____

ARE YOU PRESENTLY TAKING PRESCRIPTION MEDICATION? YES NO

IF YES, WHAT MEDICINE AND HOW MUCH? *(if you know)* _____

DO YOU SMOKE? YES NO HOW MUCH? _____

DO YOU DRINK ALCOHOL? YES NO HOW MUCH? _____

HAVE YOU EVER SEEN A SCHOOL COUNSELOR ABOUT A PROBLEM? YES NO

IF YES, DO YOU REMEMBER WHEN? _____

NAME OF COUNSELOR _____ HOW MANY TIMES? _____

HAVE YOU EVER SEEN ANOTHER COUNSELOR BEFORE OR A PSYCHIATRIST? YES NO

IF YES, DO YOU KNOW WHEN? _____ HOW MANY TIMES? _____

NAME _____

PLEASE PUT A CHECK BY ANYTHING BELOW YOU HAVE EXPERIENCED WITHIN THE PAST FEW WEEKS:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Always tired | <input type="checkbox"/> Feel like hurting someone | <input type="checkbox"/> Feeling panicky | <input type="checkbox"/> Unable to experience forgiveness or peace |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Full of energy | <input type="checkbox"/> Can't make decisions | <input type="checkbox"/> Loss of meaning to life |
| <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Bed-wetting | <input type="checkbox"/> Can't make friends | <input type="checkbox"/> Unable to pray |
| <input type="checkbox"/> Loss of weight | <input type="checkbox"/> Crying spells | <input type="checkbox"/> Fast heartbeat | <input type="checkbox"/> Lack of energy |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Unable to have fun | <input type="checkbox"/> Frequent sweating | <input type="checkbox"/> Trouble at school |
| <input type="checkbox"/> Feeling grouchy | <input type="checkbox"/> Feeling easily hurt | <input type="checkbox"/> Anxious inside | <input type="checkbox"/> Overly sensitive |
| <input type="checkbox"/> Feeling fearful | <input type="checkbox"/> Unable to relax | <input type="checkbox"/> Worried about health | <input type="checkbox"/> Overly ambitious |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Unresolved grief | <input type="checkbox"/> No one understands me | <input type="checkbox"/> Money problems |
| <input type="checkbox"/> Shaky hands | <input type="checkbox"/> Often feel sick | <input type="checkbox"/> Impatient with people | <input type="checkbox"/> Feeling tense |
| <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Feeling lonely | <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Cold feet and hands |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Not enjoying things | <input type="checkbox"/> Confused about religion | <input type="checkbox"/> Easily angered |
| <input type="checkbox"/> Feeling inferior | <input type="checkbox"/> Quick-tempered | <input type="checkbox"/> Lacking confidence | <input type="checkbox"/> Can't concentrate |
| <input type="checkbox"/> Very restless | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fighting/quarreling | <input type="checkbox"/> Depressed |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Shy with people | <input type="checkbox"/> Feeling guilty | <input type="checkbox"/> Overly ambitious |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Can't "get going" | <input type="checkbox"/> Don't like being alone | <input type="checkbox"/> Easily excited |
| <input type="checkbox"/> Anxious inside | <input type="checkbox"/> Sexual problems | | |
| <input type="checkbox"/> Feeling angry | <input type="checkbox"/> Always worried | | |
| <input type="checkbox"/> Muscles twitching or jumping | <input type="checkbox"/> Nightmares | | |
| <input type="checkbox"/> Feel like smashing things | | | |