Mindful Balance
Therapy Center

Child's Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Primary Care Physician Name & Phone # _____

Mother/Guardian's Last Name _____ First Name _____ Middle Initial _____

Email Address _____ Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone_____

Father/Guardian's Last Name _____ First Name _____ Middle Initial _____

Email Address _____ Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone_____

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Custody Status: _____

Emergency Contact: _____Phone Number:_____

With whom does child reside? _____

Other household members and ages: _____

_____

What are some of your child's strengths? _____

_____

What issues would be helpful to discuss in therapy? _____

_____

_____

Have you or anyone in the immediate family ever been to counseling before? Yes ☐ No ☐

| Who | Time Period | Counselor | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Have you or anyone in the immediate family had a psychiatric inpatient hospitalization? Yes ☐ No ☐

| Who | Time Period | Hospital | Reason |
|---|---|---|---|
| | | | |
| | | | |

Child's current medications & why prescribed: _____

_____

Past medications and why prescribed: _____

_____

Psychiatric diagnoses (note whether current or past): _____

Any medical diagnoses/medical concerns: _____

_____

Do you have any concerns related to safety in the home, including violence or child's statements to harm him/herself?

Yes ☐ No ☐ If so, please describe: _____

_____

_____

Any other information that you think would be helpful (including important past events, substance use in the home, positive family relationships, etc): _____

_____

_____

_____