2526 Saint Paul Street, LL Baltimore, MD 21218 • 443-292-6722 • www.ShawnaMurrayBrowne.com

YOUNG CLIENT INFORMATION FORM

DATE COMPLETED: ____________________

The information requested is to help me get to know you to serve you best. Please fill out this form as completely as you can. All information will be held in strict professional confidence unless otherwise directed by law.

Basic Information- YOUTH:

YOUTH FULL NAME: ____

DATE OF BIRTH: ______________________

ADDRESS: ____

CITY: ______________________________ STATE: _________________ ZIP: ___________________

EMAIL ADDRESS: ____

HOME PHONE: ___________________________________ CELL PHONE: _________________________

BY WHICH NUMBER IS THE BEST TO REACH YOU? ☐ HOME ☐ CELL

Can I send you a TEXT message for scheduling purposes only? ☐ YES ☐ NO

I cannot guarantee confidentiality when you and I communicate via telephone, fax, or email. These devices could compromise confidentiality. By understanding the inherent risks of the aforementioned devices, you can make an informed choice about when / where / how to use those tools.

In case of an emergency, who would you like me to contact? ____

Phone Number:____

Relationship to YOUTH: ____

SCHOOL ATTENDING: ____

GRADE LEVEL: ____________________________________

TELL ME ABOUT ACADEMIC PERFORMANCE: ____

____

EXTRACURRICULAR ACTIVITIES? ____

____

Basic Information- PARENT:

FULL NAME: ______________________________

DATE OF BIRTH: ______________

ADDRESS: ____

CITY: ______________ STATE: __________ ZIP: __________

EMAIL ADDRESS: ____

HOME PHONE: ______________ CELL PHONE: ______________

BY WHICH NUMBER IS THE BEST TO REACH YOU? ☐ HOME ☐ CELL

Can I send you a TEXT message for scheduling purposes only? ☐ YES ☐ NO

PARENT OCCUPATION: ____

LEVEL OF EDUCATION: ☐ HS Diploma/GED ☐ 2-year college ☐ Bachelor's Degree ☐ Master's ☐ PhD

EMPLOYER: ______________________________

SHow did you learn about Kindred Wellness? ______________________________

Health Information- YOUTH

Serious illnesses, injuries, or surgeries: ______________________________

____

____

Any conditions or different abilities that I need to be aware of? ______________________________

____

____

Current health challenges *(if any)*: ______________________________

____

____

Please list all medications/prescriptions currently taking and why: ______________________________

____

Please list any other substances you consume: ______________________________

____

Exercise? Regular diet? ______________________________

____

____

Sleep PATTERN: ______________________________

____

Feeling any physical pain in your body? Where?____

____

Ever worked with a Mental Health Professional? ☐ **YES** ☐ **NO**

If so, who? ____

Why? ____

Ever worked with a Psychiatrist? ☐ **YES** ☐ **NO**

If so, who? ____

Last seen? __________________________ Why? ____

Ever any attempts to self-harm or hurt anyone else? ☐ **YES** ☐ **NO**

If so, when and how many times?____

____

Been the victim of physical (domestic violence), mental, sexual abuse? ☐ YES ☐ NO

If so, when?____________________________ Where? By whom?

_______________________________________Was this investigated? ☐ YES ☐ NO

Been hospitalized for mental, chemical, or emotional concerns? ☐ **YES** ☐ **NO**

If so, when?__________________________ Where? ____

Why? ____

Ever worked with a life coach or mentor/ mentoring program? ☐ **YES** ☐ **NO**

If so, who? ____

____

Other relevant information: ____

____

____

Goals of Integrative Therapy- YOUTH

What would you like to change about your behaviors/development? ________________________________

____

____

How has this been a problem? ____

____

____

When did this problem first appear? ____

____

What changes have you noticed recently? ____

____

____

How have you tried to solve this problem? ______________________________

Why are you seeking help right NOW? ______________________________

How will you know when the problem is solved? ______________________________

Who will benefit most from solving this problem? ______________________________

Who might be the first to notice improvement? ______________________________

Tell me about your spiritual / religious beliefs. ______________________________

Tell me the concerns/fears you have. ______________________________

Hobbies / interests: ______________________________

Change is usually difficult. In the past, what **strengths and skills** would you say you have? ***They will be helpful in solving this problem***. ______________________________

My signature below signifies that the abovementioned information is true and accurate to the best of my ability and knowledge.

______________________________ ______________________________
Parent Signature Date

______________________________ ______________________________
Youth Signature Date

FOR OFFICE USE ONLY:

□**OOP**□**OON**