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Minor Client Admission Summary

Evaluation Date: __________________________ Referred By: _________________________________

CLIENT'S NAME: ____ DOB/Age: ____________________________

Address: ____

School/Grade/Work: ____

FAMILY STRUCTURE

Mother's Name_________________________________ Phone_____________________ Agrees to be involved? Y/N
Address: ____
Employment: ____ Education: _________________________________

Father's Name_________________________________ Phone_____________________ Agrees to be involved? Y/N
Address: ____
Employment: ____ Education: _________________________________

Any significant others involved? ____

Legal Guardian:_________________________________ Phone_____________________ Agrees to be involved? Y/N
Address: ____
Employment: _____________________________________ Education: __________________________

SIBLINGS

Name: _____________________________________ Male/Female DOB/Age_________________________
At home: Yes/No School/Grade: ____

Name: _____________________________________ Male/Female DOB/Age_________________________
At home: Yes/No School/Grade: ____

Name: _____________________________________ Male/Female DOB/Age_________________________
At home: Yes/No School/Grade: ____

Current concerns that led to referral: ____
____
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____
____
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____
____

Client's Name: ____

Other Services Involved for Client or Family

Substance Abuse Treatment Provider: ____
School: ____
Mental Health Services: ____
Court/Legal: ____
Other: ____

What has been tried before?

____
____
____
____
____

Life Domain	Strengths	Needs
Residence		
Family		
Social		
Education		
Health		
Mental Health		
Spiritual		
Legal		
Financial		

What other strengths, resources or support systems does the family have?

____
____
____
____
____
____
____

Prior therapy: Prior outpatient or inpatient therapy? Y / N If yes, please describe:
Inpatient: ____
Outpatient____
____
____

Any prior diagnostic or psychological evaluations: Y / N If yes, please list evaluators and dates__________
____

Any history of suicidal or homicidal thoughts, plans or actions: Y / N If yes, please elaborate____________
____

If there is a history of suicidal thoughts, plans or actions, are you willing to make a Safety Plan? Y / N

Legal: Past or current court involvement: Y / N If yes, please describe ____________________________
____

Educational: Highest grade completed or current grade: _____ Name of School ______________________
Behavioral and academic concerns at school: ____ aggressive; ____ destructive; ____ talks out; ____ poor attention span; ____ distractibility; ____ trouble focusing; ___ poor academic performance; ___ poor social skills; ___ disciplinary problems; ___ oppositional-defiant; _____other ______________________________

Medical: Any current or prior major medical problems or hospitalizations? Y / N If yes, please list current and past medical conditions, dates and locations of hospitalizations:
____
____
____

Primary Physician___________________________________ Phone Number ________________________

Date of last medical evaluation__________ Do you want therapist to consult with physician? Y / N

If applicable, any complications with pregnancy, labor or delivery? Y / N If yes, please describe:
____

Please describe any personal history of substance use (alcohol, recreational drugs, non-prescription drugs)
____
____

Current substance use? Y / N If yes, please describe alcohol or type of substance used, the frequency and amount used____
____

Any known or suspected history of traumatic head or brain injury: Y / N If yes, please list dates and circumstances ____
____
____

Medication history: Any past medication use? Y / N If yes, please list medications and dates prescribed
____
____

Please list **all** current medications (including vitamins, supplements, and over the counter medications taken regularly), dosage and dates ____
____
____

Please describe any other significant medical / developmental experiences from infancy to present)
____
____
____
____
____

Treatment Information and Goals:
Current diagnosis, if applicable: ____

Current symptoms, concerns or problem areas to address in therapy:

1. ____
2. ____
3. ____

Additional information about these current symptoms, concerns or problem areas:
____
____
____

Trigger(s) for onset of current symptoms, concerns, or problem areas:
____
____

Concerns about therapy or the therapeutic process? _______________________________
____
____

What are your goals or expectations of therapy? Please, be as specific as possible
____
____
____
____
____
____
____

Are you able to commit to regular attendance? Y / N