Jesús E. Reyes, L.C.S.W.

Minor Client Information Form

Parent/Guardian Name: _____ Date of Birth: _____ Date: _____

Home address: _____

E-mail address:_____

Telephones: Home: _____ Cell: _____

Child's Name: _____ Date of Birth: _____ Grade: _____

School – Name and City: _____

Emergency contact (name, relationship, telephone number): _____

Active Insurance Coverages:

Primary Insurance	Subscriber Name	Member ID	Group Number	Plan Code
_____	_____	_____	_____	_____

What brings your child to therapy?

_____

_____

_____

_____

_____

_____

Medical/Psychiatric physician(s):

Name and Specialty	Address and telephone	Last exam date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Present and past medical care and dates (major problems, accidents, hospitalizations, current medication):

_____

_____

_____

_____

_____

_____

PAST/PRESENT COUNSELING/PSYCHOTHERAPY/MENTAL HOSPITALS:

1. Hospital or Therapist: _____ Dates: _____ to _____

Address: _____ Phone: _____

Initial reason: _____

_____

Diagnosis, treatment, and outcome:_____

_____

_____

2. Hospital or Therapist: _____ Dates: _____ to _____

Address: _____ Phone: _____

Initial reason: _____

_____

Diagnosis, treatment, and outcome:_____

_____

_____

Family history of alcoholism or other substance abuse, mental illness, violence, suicide:

_____

_____

_____

_____

_____

_____

Please use the back of this form to add further information on any item above or other relevant information.