Lisa Lawhon, BSN, LMFT

5409 Maryland Way, Suite 305

Brentwood, TN 37027

615-293-4242

lisa@lisalawhoncounseling.com

Minor Client Information

Today's Date:_____ Referred by:_____

Child Name:_____ Child DOB:_____

Parent/Guardian(s):_____

Parent/Guardian(s) DOB:_____

Parent(s) Occupation:_____

Parent Work Phone:_____ Home phone:_____ Parent Cell:_____

Client cell:_____

Home Address:_____

E-mail addresses (parents):_____

Parent's Marital Status: _____

List members of your family and/or all others living in your home:
(Name/Sex/ Age/Relationship to client)

Briefly describe your reason for seeking help for your child:_____
_____

When was your child last examined by a physician?_____
Name & phone number of Physician:_____

List any major health problems for which your child currently receives treatment:_____
_____

List all medications your child is now taking:_____
_____

Has your child received psychiatric or psychological treatment or counseling before? ____Yes____No
If yes, please give name(s) of provider(s), location(s) and treatment dates:

_____

_____

Please circle all that apply to your child:

NERVOUSNESS	DEPRESSION	PANIC ATTACKS
LOSS / GRIEF ISSUES	SLEEP PROBLEMS	SELF-INJURY
DRUG/ALCOHOL USE	LONELINESS	SADNESS
ANGER	FAMILY PROBLEMS	IRRITABILITY
PORNOGRAPHY	SELF-WORTH	AVOIDANCE OF CERTAIN PLACES
FINANCIAL CONCERNS	PARENTING PROBLEMS	TRAUMA HISTORY
SEXUAL COMPULSIVITY	LACK OF CONCENTRATION	SOCIAL CHALLENGES
SUICIDAL THOUGHTS	HEADACHES	SCHOOL REFUSAL
STRESS	PROBLEMS AT SCHOOL	WORRIES
FEARS	HEALTH CONCERNS	CHANGE IN APPETITE
SEPARATION	TROUBLE WITH FRIENDS	PESSIMISM
OTHER:		

Emergency contact & number:_____

Relationship:_____

I have/will read the practice policies section and agree to abide by the terms. ___Yes___No

Signature of responsible party:_____

Relationship to Child: _____

Date: _____