

Play Therapy for children

367 Riverside Dr. Suite 117

Franklin, TN 37064

615-347-8369

**Minor Client Questionnaire**

(Please print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date Referred by

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child Name Parent/Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School/Grade Parent Occupation

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone Parent Cell Phone Parent Work Phone

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address Parent Street Address (if different)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City ST ZIP City ST ZIP

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_-\_\_\_-\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_-\_\_\_-\_\_\_\_

Date of Birth Social Security # Parent DOB Parent SS#

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent E-mail address

Parents Marital Status: Single\_\_\_\_ Engaged\_\_\_\_ Married\_\_\_\_ Separated\_\_\_\_ Divorced\_\_\_\_ Remarried\_\_\_\_

List members of your family and/or all others living in your home:

**Name: Sex Age Relationship to child**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Significant Life Events in the last 2 Years:**

 Death of a Loved One

 Move/School Change

 Parent remarriage/step siblings

 Birth of a new sibling

 Trauma (violence, natural disaster, car accident etc)

 Financial problems in Family

 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Strengths or Abilities:**

 Academics/Grades  Sports

 Creative(art, music, dance etc)  Care for Others

 Sense of Humor

 Group Involvement (Clubs, Organizations)

 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Concerns about Your Child:**

 ANXIETY/NERVOUSNESS  DEPRESSION

 LOSS / GRIEF ISSUES  SLEEP PROBLEMS

 DRUG/ALCOHOL USE  HEALTH CONCERNS

 ANGER/IRRITABILTY  SEPARATION ANXIETY

 PORNOGRAPHY  SELF-IMAGE

 TROUBLE WITH FRIENDS  TROUBLE WITH FRIENDS

 SEXUAL BEHAVIOR  LACK OF CONCENTRATION

 SUICIDAL THOUGHTS  HEADACHES/STOMACH ACHES  PROBLEMS AT SCHOOL  EATING/FOOD ISSUES

 SENSITIVE TO TOUCH, SOUND LIGHT, MOTION

OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Briefly describe your reason for seeking help at this time:

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**Child’s Developmental History:**

Problems with….?

 Sitting up  Walking  Talking  Toileting  Bedwetting

 Writing letters

 Reading or Letter Identification

 Physical Coordination (running, jumping, climbing

 Responding to discipline or behavior management

 Anger/temper tantrums

 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List any major health problems for which he/she currently receive treatment:**

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List all medications he/she is now taking:

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Has child received psychiatric or psychological treatment or counseling before? Y N

If yes, please give name(s) of provider(s), location(s) and treatment dates:

When was child last examined by a physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_

**Child’s Academic History:**

Current School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade\_\_\_\_\_\_\_\_\_\_\_\_

Teacher(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any current school issues (IEP, special services or suspensions etc)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Family History:**

Has anyone in your family struggle with:

 Depression or Bipolar Disorder  Anxiety

 Learning Problems  Attention Problems

 Excessive alcohol or drug use

 Sexual Abuse  Physical Abuse

 Suicide Attempts or Completion

 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What do you hope to accomplish by working with me?**

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

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Signature of responsible party Date

Relationship to Minor child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_