Better Together Counseling (Elisa Horton, LMFT, LMHC, NCC, Inc) - FL License Numbers MT2182, MH8749, NCC 79676

Child/Teen Clinical Information Form for Medical Record

Client's name: ____ Date of packet completion: ___________
Parent/Guardian Name : ____
Address: ____
Phone Number (where a message can be left): (_______)____

Emergency Contact (☐same as parent/guardian): ______________________________Relation: ________________
Address: ____
Phone Number (where a message can be left): (_______)____

Presenting Problem:
Please briefly indicate the concern(s) that bring your family into counseling at this time:___________________________
____
____

How long have you been dealing with this concern? ____

What has help? ____

What has made things worse? ____

What specific goals/objectives would you like to work on in therapy? Please make them about changes you would like to make not changes you'd like others to make.

1. ____
   ____
   ____
   ____
2. ____
   ____

How will you know when therapy has successfully been completed? ____
____
____

What do you wish your loved ones knew the most about your feelings for them and the relationship? Does anything ever get lost when you talk? ____
____

Coping Tools/Self Care: What do you do to take care of yourself socially, physically, intellectually/mentally, creatively, emotionally, & spiritually? ____
____

Personal Strengths: What do you like about you and/or what do others like about you? ___________________________
____
____

Family:
Please tell me about who is in your current household:

Name, age, & relationship to you	Quality of relationship	Live with you full time?	Give 1-5 words that describe them
		❍Yes ❍ No	
		❍Yes ❍ No	
		❍Yes ❍ No	

		❍Yes ❍ No	
		❍Yes ❍ No	
		❍Yes ❍ No	

Were you adopted or are you being raised by someone other than your parents? ❍ Yes (at what age? ________ Are you in touch with your bio parents? _______) ❍ No

Are your parents or caregivers/people that primarily raise you: ❍ Never married and still together ❍ Never married and separated (how old were you?____________) ❍ Married and still married ❍ Married then divorced (how old were you? __________) ❍ Married now widowed (how old were you when your first parent passed? ___________)❍ Never married now widowed (how old were you when your first parent passed? ___________)

Family Relationship Questions:
Do you feel satisfied with your connection with your family? ❍Always ❍ Mostly ❍ Rarely ❍ Not at all
Please explain:____
What are your family's strengths? ____

When there is tension between you and your family do you (check all that apply): ☐ yell ☐ get critical ☐ tell my family member what they did wrong ☐ get defensive/try to explain myself ☐ follow my family member around trying to get them to talk to me ☐ ask a lot of questions ☐ point prove ☐ make threats ☐ get quite/silent ☐ get analytical ☐ tell my family member how to solve the problems ☐ leave the scene ☐ isolate ☐ stop the conversation or change the subject ☐ shut down emotionally ☐ go find something to do ☐ other:
____

Psychiatric or Substance Misuse Hospitalization/Residential Treatment Facility History: ☐ N/A.
Have you *ever* been hospitalized or received in-patient treatment for a mental health or substance abuse issue? ❍Yes ❍ No

Year	Length of Stay	Voluntary Y/N	Treatment Facility	Reason(s)
		❍Yes ❍ No		
		❍Yes ❍ No		

Psychiatric Care: ☐ N/A.
Are you currently seeing a psychiatrist ❍Yes ❍ No – if yes, please list their name and contact information here:
____
Do they know you are seeing me? ❍Yes ❍ No – If No, can they be informed? ❍Yes ❍ No (if yes, please sign a release)

Please inform me of your psychiatric history:

Name of Psychiatrist:	Medication RX: Dosage, Frequency:	For what diagnosis/symptoms?	Currently still taking?
			❍Yes ❍ No
			❍Yes ❍ No

Counseling:
Are you currently seeing another therapist? ❍Yes ❍ No – if yes, please list their name and contact information here:
____
Do they know you are seeing me? ❍Yes ❍ No – If No, can they be informed? ❍Yes ❍ No (if yes, please sign a release)

Please inform me of your psychotherapeutic history:

Name of therapist	When seen (approx date) & length	For what diagnosis/symptom?

Medical:

Current non-psych meds and/or supplements	Dosage & Frequency:	Prescribed by Whom & Type of Doctor	For what diagnosis/symptom:

How do the above diagnoses affect you currently in your daily life and relationships? ☐ N/A ________________________
____

Please indicate any current medical issues or symptoms that you have not told your doctor about: ☐ N/A ______________
____

Please indicate any and all medications and other substances to which you are allergic: ☐ N/A ____________________
____

Please describe relevant past medical history (i.e. hysterectomy, cancer, strokes, heart attacks): ☐ N/A _______________
____

Personal History:

Please list any issues your mother had when pregnant with you or during your birth and any known developmental issues you faced as a child (e.g. delayed speech, stuttering, significant medical issues, prolonged separation from your caregiver, abuse, neglect, exposure to domestic violence, difficulty in school, etc): ____
____
____

School:

Where do you go to school? ____ What grade are you in?_________

Please check all that apply: ☐ I like school ☐ I hate school ☐ I have enough friends ☐ I get bullied ☐ I get good grades ☐ I don't fit in ☐ I'm involved in clubs, sports, or band ☐ other: ____

Family Medical History:

Please indicate any significant family medical history: ☐ N/A, ☐ cancer, ☐ cardiac disease, ☐ thyroid or endocrine problems, ☐ HBP, ☐ stroke, ☐ other: ____

Please indicate any family history of psychological symptoms or disturbances: ☐ N/A ☐ depression ☐ anxiety ☐ bipolar ☐ psychosis ☐ addiction ☐ other: ____

Substance Use: ☐ N/A

Substance	Current Use?	Past Use?	Age of 1st use?	Age of last use?	Legal, Vocational, Medical, or Relational consequences?	Quantity of servings per week on average in last 3 months:	Do you feel it's a current problem for you?	Have you had treatment for it?
Alcohol	❍Yes ❍ No	❍Yes ❍ No			❍Yes ❍ No		❍Yes ❍ No	❍Yes ❍ No
Nicotine	❍Yes ❍ No	❍Yes ❍ No			❍Yes ❍ No		❍Yes ❍ No	❍Yes ❍ No
Pot	❍Yes ❍ No	❍Yes ❍ No			❍Yes ❍ No		❍Yes ❍ No	❍Yes ❍ No
Prescriptions not prescribed to me	❍Yes ❍ No	❍Yes ❍ No			❍Yes ❍ No		❍Yes ❍ No	❍Yes ❍ No
Other:	❍Yes ❍ No	❍Yes ❍ No			❍Yes ❍ No		❍Yes ❍ No	❍Yes ❍ No

Is someone else's substance use affecting you? ❍*Yes*❍ *No*

How does their behavior affect your relationship? ____

Other addictions: ☐ N/A

Do you currently engage in any addictive behaviors? ❍yes - please explain: _________________________________ ❍no

Is someone else's addictive behavior affecting you? ❍*Yes*❍ *No*

How does their addictive behavior affect your relationship? ____

Risks:

Are you currently feeling like you want to hurt or kill yourself? ❍yes ❍no Do you have a plan? ❍yes ❍no
Are you currently feeling like you want to hurt or kill someone else? ❍yes ❍no Do you have a plan? ❍yes ❍no
Do you purposefully, physically hurt yourself? ❍yes ❍no – If yes – how: ____

Are you currently being abused? ❍yes ❍no If yes, by who, how & do you need help? ____________________________
Are you currently involved in or being exposed to a relationship that contains domestic violence? ❍yes ❍no When was the last occurrence (approximate date): __________________.

*Do you have a history of ANY of the previous risks listed above? ❍yes ❍no If yes, please explain & provide timelines:
____
____

Traumatic Events (where you have experience fear of harm or death to you or someone else): ☐ N/A

Event/What	How long ago?	If it is affecting you now – how so?

Loss History: (i.e. death of a loved one or pet, divorce, job, etc) ☐ N/A

Who/What	How long ago?	If it is affecting you now – how so?

Attachment Injury History: (i.e. affair, divorce, abuse, breaches of trust, abandonment, rejection, etc) ☐ N/A

Attachment injury & approx date	By who	How it affects your relationships now:

Religious/Spiritual Orientation: ☐ N/A. Please note your orientation: ____

Sexual Orientation: ____

Military History: ☐ N/A.
Tell me about you or your family's service, experience, and how it has affected life and/or the reasons you are coming:
____
____

Other information about me not otherwise covered that it would be good for my therapist to know: ______________
____
____