BRIGHT HOPE
Christian Counseling Center, PLLC

Serving Individual Adult, Adolescent, Children and Couples

270 North Main, Logan, UT 84321 – Phone: 801-317-4410 – Fax: 435-227-0401 – Email: karen@bhccc.org – Web: https://bhccc.org

CLIENT INFORMATION - MINOR

Client First Name: _____ **Client Last Name**:_____

Date of Birth: _____ **Gender**: _____ **Race/Ethnicity**: W H NA AA A

Age: _____ **Weight**: _____ **Height**: _____ **Eye color**: _____

Nationality: _____ **Primary Language**: _____ **Interpreter Needed**: Y N Unsure

Mother's First Name: _____ **Mother's Last Name**:_____

Father's First Name: _____ **Father's Last Name**:_____

Living Situation: Home / Homeless / Shelter / Foster Home / Group Home / Other: _____

Home address 1: _____

Home address 2: _____

Student: FT PT Homeschool Boarding School Drop-out Education Level: _____

Emergency Contact (Name, Phone number & relationship to client):

_____

How were you referred to Bright Hope Christian Counseling Center: _____

Personal Information:

Briefly describe your current need to see a mental/behavioral health therapist:

_____

_____

Trauma / Abuse / Witnessed Parents' Violent Fights Information:

Have you ever been left alone without food to eat, clean clothes to wear, a safe place to sleep in? YES NO UNSURE

Have you ever been beaten where you bled, had broken bones, scars on your body? YES NO UNSURE

Have your parents, adult family members, teachers called you demeaning names? YES NO UNSURE

Have you ever experienced any adults criticizing, dismissing, demeaning, ridiculing you? YES NO UNSURE

Has anyone touched you in your private places and/or put inappropriate things inside you? YES NO UNSURE

Have you ever seen and/or heard your parents, step-parents, parents' significant other fighting? YES NO UNSURE

Self-harm, suicidal & homicidal Information:

Do you currently have thoughts of hurting or harming yourself? YES NO UNSURE

Do you currently have thoughts of killing yourself? YES NO UNSURE

Do you currently have thoughts of killing or hurting someone else? YES NO UNSURE

Family Psychiatric (mental health diagnoses) History:

Father:

Mother:

Siblings:

Extended Paternal Family:

Extended Maternal Family:

Medical Information:

Primary Care Physician: _____, MD / DO / PA / FNP / FNP-C

Practice Name and Location: _____

Serious Head Injury: Yes / No / Unsure

Allergies:

Non-Psychiatric Surgeries / Hospitalizations & year:

Illnesses / Conditions:

Headaches Dizziness Fatigue Seizures Eating Disorder Cancer Diabetes Hearing/Vision Problems

Problems Sleeping: falling asleep / staying asleep / frequent waking Immune System Problems Heart Condition

Kidney Disease Liver Disease Lung Disease TB Symptoms/Diagnosis Stomach Disease/Ulcer/Ache/Pain

Other Important Medical Conditions:

Current Medications (Name, Dosage, Prescriber, Over-the-counter, Response to Medications)**:**

Substance Use / Abuse & Treatment Information:

Tobacco use

First used: Age ____ years old Never smoked Former Smoker Smoke Daily Smoke Occasionally

Smokeless Tobacco Only Vaping daily / occasionally Other:

Withdrawal / Tolerance level / symptoms:

Alcohol use

First used: Age ____ years old Never drank Former Drinker Drink Daily Drink Occasionally

Quantity consumed:

Last Date of Use:

Withdrawal / Tolerance level / symptoms:

Illegal drugs use / abuse: Yes / No / unsure Names & year:

Misused legal substance (prescription pills): Yes / No / unsure Names & year:

Significant loss / consequences / outcomes related to substance use / abuse:

Past / current substance abuse treatment / treatment recommended / prompted by criminal justice system or juvenile court:

Treatment History / Outcome:

Legal Information:

Have you ever been: Arrested Incarcerated Sentenced DUI occurrences Litigation Other:

Have you been arrested in the past 30 days: Yes / No / unsure

Details of your recent police arrest(s) / encounters:

Current Legal Information: Probation Protective Order Custody Dispute Juvenile Court Jurisdiction Parole

Foster Care Divorce Community Placement Civil Stalking Injunction Secure Facility

Other:

Civil Commitment (Court-ordered Psychiatric Treatment): Yes / No / unsure / Unknown

Details of civil commitment:

Development Milestones: Normal / Advanced / Delayed

Nursing Crawling Walking Climbing Running Skipping Talking Potty-Training Coloring Writing Reading

Other:

Education Information:

Name & City of Current School:

Learning Disability Needs:

Disciplinary Issues:

Acknowledgment & Signature:

I have read and agreed to the terms outlined in this document, **CIENT INFORMATION – MINOR.** I acknowledge that I am the Client, or a legal representative of the client. I agree that my e-signature below is a legally binding equivalent to my handwritten signature.

Client Name (Print): _____

Client Signature: _____

Today's Date: _____

Father's Name (Print): _____

Father's Signature: _____

Today's Date: _____

Mother's Name (Print): _____

Mother's Signature: _____

Today's Date: _____