CLIENT INFORMATION

JR Counseling, LLC
11329 P Street, Suite 113
Omaha, NE 68127
(402)819-7885

DEMOGRAPHIC INFORMATION

Child's name: _____

Child's date of birth, age: _____

Caregiver's name and phone number: _____

Caregiver email address: _____

Preferred mailing address: _____

Please check all that apply:

Race/ethnicity: □ White □ African American □ Asian □ Native Hawaiian
□ Hispanic, Latino, or Spanish Origin □ American Indian
□ Another Race □ Prefer not to answer

Gender: □ Female □ Male □Intersex □Transgender
□ Transsexual □ Genderqueer/androgynous
□ Prefer not to answer □ Other _____

EMERGENCY CONTACT

Name: _____

Phone number: _____

Relationship: _____

INSURANCE INFORMATION

□ Please check the box if the address to submit claims is the same address provided above. If different, please provide address _____
_____

Primary insurance: _____ Phone number: _____

Name of policy holder: _____ DOB for policy holder: _____

Policy/group #: _____ Member ID #: _____

PRESENTING CONCERN

Briefly describe the reason for seeking therapy services:

_____

_____

_____

RISK ASSESSMENT

Below are several questions that I ask every client who visits with me. All your responses help me better understand your presenting concern and how treatment may look moving forward.

	Please circle	
In the last 6 months, have you had any thoughts about suicide?	Yes	No
Have you ever attempted to kill yourself?	Yes	No
In the last 6 months, have you intentionally hurt/injured yourself?	Yes	No
Have you ever received medical attention for self-harm behaviors?	Yes	No

MENTAL HEALTH HISTORY

	Please circle	
Have you received mental health services before?	Yes	No

If yes, please indicate:

Reason for treatment _____

Name of provider _____

Diagnoses _____

Length of treatment _____

Please indicate any known family mental health. *If yes, please indicate relationship to family member*

	Please circle		Relationship to family member
Anxiety (general):	Yes	No	_____
Depression:	Yes	No	_____
Suicide Attempts:	Yes	No	_____
Completed suicide:	Yes	No	_____
Bipolar/Manic Depressive:	Yes	No	_____
Substance Abuse:	Yes	No	_____

Domestic Violence:	Yes	No	_____
Eating Disorders:	Yes	No	_____
Schizophrenia:	Yes	No	_____

SUBSTANCE USE AND ADDICTIVE BEHAVIORS

Do you have past or current use with any of the following?

	Please circle		**If yes, please describe**
Nicotine:	Yes	No	_____
Vaping:	Yes	No	_____
Alcohol:	Yes	No	_____
Drugs:	Yes	No	_____
Gambling:	Yes	No	_____
Pornography:	Yes	No	_____

LEGAL HISTORY

Please list any past or pending legal charges.

Charge/conviction	**Year of charge/conviction**
_____	_____
_____	_____
_____	_____

EDUCATION

School name: _____
Current grade: _____
General attitude toward school: _____
Individualized education plan: _____
Typical grades: _____

FAMILY AND RESIDENCE

Name and Relationship

Please list family members: _____
(Parents and siblings) _____
_____
_____
_____
_____

Describe current living situation: _____
_____
_____

MEDICAL

Please indicate

Do you have allergies? Yes No
If yes, please indicate: _____
Do you have a visual or hearing impairment? Yes No
If yes, please describe: _____
Who is your primary care physician? _____
Date of last physical exam: _____
Please list your child's current medications:
_____
_____

SOCIAL SUPPORT

Briefly describe how your child gets along with other children and adults:
_____
_____
_____

Briefly describe your child's strengths and challenges:
_____
_____
_____

STRESSOR(S)

Have you experienced any stressors in the last year that may be contributing to your presenting difficulties? Examples: illness, death(s), car accidents, divorce, change in employment, negative sexual experience, moves, etc.
If yes, please describe:

_____

_____

_____

_____ _____

Caregiver/Guardian signature Date

_____ _____

MS, PLMHP, NCC Date