Linda Arbiter, MA, MFT
Licensed Marriage and Family Therapist MFC #45100
4910 Van Nuys Blvd.. #301 Sherman Oaks, CA 91403
818 754-4754 voice/fax

CLIENT INFORMATION FORM - ADOLESCENT

GENERAL INFORMATION Today's Date _____

Client's Name _____ Referred by _____

Address/City/Zip _____Cell phone _____

Home Phone_____ e-mail address: _____

Birthdate _____ Age _____ Social Security # _____

Driver's License # _____ Car Make _____ Lic. # _____

EMPLOYMENT (Parent/Guardian) & SCHOOL (Child/Adolescent)

Dad/Guardian Occupation _____ Employer _____Work phone _____

Mom/Guardian Occupation _____ Employer _____Work phone _____

Name of minor's school _____ City _____Phone _____

Grade ____ School Counselor _____ Grades in current classes _____

Favorite Subjects _____ Least Favorite _____

Extracurricular Activities _____

INSURANCE (If more than one, indicate additional coverage)

Name of Company _____ Phone _____

Address/City/State/Zip _____ Group/Policy # _____

Insured's Name _____ Social Security # _____

Relation to Client _____ Does insurance cover Ph.D./MFT outside of network? Yes___

PERSONAL / FAMILY INFORMATION

Parents' Marital Status _____

If divorced or not with parent, who has legal custody? _____ physical custody? _____

what is visitation arrangement? _____

Names/ages of siblings (from this/other marriages) _____

Emergency Contact, if those in house cannot be reached:

Name _____ Relationship _____ Phone(s) _____ **OVER**

CONFIDENTIAL INFORMATION (if age 12 or older, will be shared with parent ONLY if life-threatening)

COUNSELING/PSYCHOLOGICAL HISTORY

Are you CURRENTLY seeing another psychotherapist or counselor? Yes If so: Phone _____

Name _____ For how long? _____ For what purpose(s)? _____

Have you PREVIOUSLY been in psychotherapy or counseling? Yes If so: When? _____

For how long? _____ For what purpose(s)? _____

Outcome/Results? _____

What worked/did not work for you in that therapy?_____

Purpose for today's consultation: _____

☐ Problems with boy/girlfriends or sexual matters? _____

☐ Learning disabilities/academic problems? _____

☐ Alcohol, drug, or tobacco dependence or frequent use? _____

☐ Eating disorder(s)? _____

☐ Self-injury or other addictive or compulsive behavior(s)? _____

☐ Anger, arguments, domestic violence? _____

☐ Depression or suicidal thoughts? _____

☐ Anxiety or panic attacks? _____

☐ Other? _____

MEDICATIONS AND MEDICAL HISTORY

Please list ALL prescription medications you are CURRENTLY taking:

_____

Please list any PREVIOUS medications you have taken for psychological purposes:

_____

Amount of CURRENT use:

Tobacco _____ Alcohol _____ Caffeine (coffee/cola/chocolate) _____

Sugar _____ Other drugs (specify) _____

Other physical or medical conditions: _____

Date of last medical exam _____ Doctor's Name _____ Phone _____

Other useful information to assist in counseling: _____