Center for Personal Growth
Owner: Erin M Liebich, Psy.D
Carol Stream, IL 60188
(630) 791-0118 ReceptionDesk@center4PersonalGrowth.net *Fax (630) 708-7654*

**CONFIDENTIAL CHILD / ADOLESCENT CLIENT HISTORY**
**To be filled out by the child AND guardian**

Client's Name: ______________________________ Age: _______ Date of birth: ___________

Legal gender (circle): Male / Female Gender Identity:__________________________________

Preferred Gender Pronouns (circle): He/His or She/Hers Other:___________________________

Primary Address: _____________________________________________________________________

Cell Phone Number: (_____)_________________ preferred method of contact: calls text

What Phone number would you like us to text the appointment reminder? ___________________

Legal Guardian#1 Name:______________________ Relationship to Client: _______________

#1's Phone: ___________________ H / W / C Can we leave a detailed Message? Y N

Can we leave a message regarding scheduling? Y N

Preferred Method of Contact: ____Call ___Text ___Email:_______________________

#1 Guardian's Address: _______________________________________________________________

Street Apt City Zip

Legal Guardian#2 Name:______________________ Relationship to Client: _______________

#2's Phone: ___________________ H / W / C Can we leave a detailed Message? Y N

Can we leave a message regarding scheduling? Y N

Preferred Method of Contact: ____Call ___Text ___Email:_______________________

#2 Guardian's Address: _______________________________________________________________

Street Apt City Zip

*Primary Insurance Holder (*please check*) ☐ Guradian #1 ☐ Guradian #2

*Primary Insurance Holder's Date of Birth: ____________________

**HISTORY OF TREATMENT (Therapist will see this so please fill out)**

Has the client / immediate family ever received psychological services for emotional or substance abuse problems? _____ Yes _____ No

Explain if yes: ______________________________________________________________________

______________________________________________________________________

Problem treated for: ______________________________________________________________

Provider: _____________________________________________ When treated? ___________

Any significant details about **family members**? ________________________________________

______________________________________________________________________

Any **family** history of **mental health treatment**? ______________________________________

______________________________________________________________________

Any significant individuals (other than family) in the home or client's background? __________

______________________________________________________________________

Significant life events (include births, deaths, moves, traumatic events): ____________________

______________________________________________________________________

Current medications (name, frequency, and dosage):_____________________________________

______________________________________________________________________

______________________________________________________________________

**Check ALL that apply to the client in the last 6 months (for therapist to review)**:

___ Being overly irritable
___ Being overactive
___ Being impulsive
___ Being disorganized
___ Feeling anxious
___ Feeling overwhelmed
___ Feeling sad / down
___ Relationship difficulties
___ Feeling worried a lot
___ Engaging in risky behavior(s)
___ Using cigarettes/alcohol (_____ day/week/month)
___ Using drugs other than as prescribed
___ Thoughts of hurting self or others
___ Having feelings of unreality
___ Feeling uncomfortable around others
___ Compulsions (doing things over & over)
___ Obsessions (thoughts you can't get rid of)
___ Thoughts of death
___ Suicide attempt
___ Withdrawal/isolation

___ Decreased interest in activities
___ Decreased enjoyment
___ Change in sleeping patterns
___ Change in eating patterns
___ Decreased ability to concentrate
___ Difficulty making decisions
___ Feeling on top of the world
___ Feeling excessively tired
___ Feeling worthless or guilty
___ Feeling judged by others
___ Feeling restless or slowed down
___ Significant weight change
___ Temper outbursts / aggression
___ Too much energy
___ Excessive fears
___ Panic attack(s)
___Confusion about gender
___Gender dysphoria
___Concern about sexual behavior
___Difficulties with urination/bowel

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___ Agitation/being upset
___Constantly defiant toward authority figures
___ Losing track of time
___ Losing things
___ Feeling disconnected from oneself
___ Unpleasant thoughts about an event
___ Seeing or hearing things others don't
___Eating things other than food
___ Over sensitivity to noises
Other:___________________________
_________________________________
_________________________________
_________________________________
_________________________________

**EDUCATION**

Current school or last school attended: _______________________________________________

Grade level: ______________ District: __________ City: _______________

Academic functioning (grades): ______________________ Did the client ever receive special services in school? YES NO Academic difficulties or special needs? YES NO

*Would You like to fill out a release/obtain information sheet for us to talk to anyone at the school?

YES NO

Social Worker's Name: ________________________________

If applicable, whom referred you for treatment (name and relationship to you): _____________
_________________________________________________________________________________

I certify that the information above is complete and accurate:

**Client's Signature**: ___________________________________ **Date**: _______________

**Parent/Guardian's Name:**________________________**Relationship to client:** ________________
(*print*)

**Parent/Guardian's Signature**: ___________________________________ **Date**: _______________