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Client Data Form/Youth

Name _____ Male _____ Female _____ Dob _____

Parent's Name _____

Home # _____ Cell# _____ Work# _____ May we leave a message? Y _____ N _____

Address _____ City _____ State _____ Zip _____

By whom were you referred? _____

Youth: in your own words, what problem or difficulties bring you here? _____

When are these problems worse? _____

When are these problems better? _____

What do you hope to accomplish in therapy? Be specific. _____

Have you tried to get help before? _____ What kind/when? _____

Was it helpful? _____ How? _____ Reason for termination? _____

When did these problems first begin? _____

How have you tried to work on this on your own? _____

What important things have happened to you or your family in the last six months? _____

Education

Current Grade _____ How do you feel about school? _____

What are your strengths? _____ What are your weaknesses? _____

Talk about your friends: _____

Who has been significant in your life? _____

What interests or hobbies do you have? _____

What clubs or organizations are you involved with? _____

What if any, religious affiliation do you have? _____

Have you ever lost control of yourself? If so, please explain: _____

Are you currently having any thoughts of suicide? If so, please explain: _____

Parent's: In your own words, what problems bring you here? _____

When are these problems worse? _____

When are these problems better? _____

What do you hope to accomplish in therapy? Be specific _____

Have you tried to get help before? _____ What kind, when? _____

Was it helpful? _____ How? _____ Why was treatment terminated? _____

Have you tried to work on these things on your own? _____ How? _____

What important things have happened to you or your family in the past 6 months? _____

Health History

Family Physician: _____ Phone# _____

Address _____

Date of last physical _____ Describe any serious illnesses your child has had (include dates) _____

Medication	Dosage	Medical Condition	How long?	Physician
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Hospitalizations? _____

Family History

Father's name _____ Age _____

Mother's name _____ Age _____

Are parents: married _____ separated _____ divorced _____ remarried _____ If so, when: _____

How old was client? _____ Client's relationship with each _____

Please list siblings of client along with their ages: _____

History of abuse for client:

_____ Physical abuse _____ Sexual abuse/assault _____ Domestic violence

_____ Emotional abuse _____ Other trauma

Please explain: _____

Cultural/Ethnic/Spiritual

Cultural/ethical/racial issues that need consideration: _____

Religious/spiritual issues that need consideration: _____

Legal History

Any involvement with the legal system? Explain: _____

Other comments:

Client Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Reviewed/Completed by Clinician _____ Date: _____