Cynthia White Meyer, LICSW

2677 N Innsbruck Dr. Ste. A (Innsbruck Professional Center)
New Brighton, Minnesota 55112
(651) 321-1970 fax: (651) 633-9485

Client Identification Data

Client Name (Last) (First) (M)	Age	Birthdate	Sex

Address	City	State	Zip

Parent's Cell phone: OK to call? _____	Home Phone: OK to call? _____	Work Phone: OK to call? _____

☐☐☐☐☐ Parent's Marital Status Single Married Divorced Separated Widowed	Parents email address

Child's Education (Highest Grade Completed)	Primary Health Insurance Company – ID#	Secondary Health Insurance Company ID
If divorced whose consent is needed to provide services:		

Family History

Family Members	**Age**	**Living in Household**		**Living?**		**Occupation**
		Yes	**No**	**Yes**	**No**	
Mother's Name						
Father's Name						
Step parent's name (If applicable)						
Sibling's Name (if applicable)						
Sibling's Name (if applicable)						
Other significant person in your household						

Notify in case of emergency (Name, relationship, phone number for contact)	
Address	Home Phone
Print Name of Client	Date
Signature of client or legal guardian	Date

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Health Data			
Your Physician (Full Name):			
Address (Clinic Name)	(Street)	(City)	(State/Zip)

Date of most recent physical: _____

Do you have any current medical problems (including any infectious diseases)? ___yes ___ no Please describe:

_____

Are your medical problems being treated? _____ If yes, by whom? _____

Have you ever had a drug allergy or sensitivity? __yes __no If yes, to what drug:_____

Medications:

Current Meds: _____

_____

Prescribing MD: _____

Counseling and psychiatric history: (dates of tx, hospitalization, provider/tx and outcome, etc)

__Outpatient tx __IOP __Partial hospitalization __Inpatient hospitalization __Residential tx

Name of Facility/Doctor/Address:

_____

_____

Additional Info:_____

Any trauma history – accidents, injuries, illness, losses, death of loved one, other

_____

_____

_____

Other factors that impact client's life (e.g. cultural issues, military, spiritual and/or legal issues)

Legal issues: __No __Yes (describe if yes)_____

Military: __No __Yes (describe if yes)_____

Cultural issues: __No __Yes (describe if yes)_____

Spiritual beliefs/practices: _____

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Abuse History

Hx of abuse: __no __yes If yes: __physical __sexual __verbal/emotional **Legal Action**: __no __yes

By: _____

When: _____

Family Mental Health History: (include family hx of suicide/homicide**) :**

Maternal side: __depression __anxiety __bipolar __eating disorder __alcoholism __drugs __suicide

Paternal side: __depression __anxiety __bipolar __eating disorder __alcoholism __drugs __suicide

Additional information: (who, treatment, other diagnoses, etc)

_____

_____

Presenting situation: (include reason for making appointment, precipitating events, onset, course of symptoms)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Client's name: _____Date: _____

Parent/Guardian _____

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CLIENT NAME_____ **DATE**_____

Form completed by: _____

Current Symptom Checklist: Rate the intensity of symptoms present in the last 4 weeks.

None: This symptom not present at this time **Mild:** Impacts quality of daily life, but no significant impairment of day to day functioning **Moderate:** Significant impact on quality of life and/or day-to-day functioning
Severe: Profound impact on quality of life and/or day to day functioning

Symptom	None	Mild	Moderate	Severe	Symptom	None	Mild	Moderate	Severe
epressed Mood					Increased/decreased appetite				
Low Energy					Unplanned weight gain or loss				
ep disturbance					Cruelty to animals				
Dissociation					Paranoid thoughts				
Hyperactivity					Poor concentration or Indecisive				
Bingeing					Purging / Over-exercising				
Nightmares					Excessive worrying				
nresolved guilt					Impulsive actions/speech				
Irritability					Anger management problems				
ea/Acid indigestion					Vandalism / stealing				
Social Anxiety					Hallucinations				
mutilation/cutting					Racing thoughts				
ow self worth					Restlessness				
Nightmares					Loss of interest in normal activity				
y (skipping school)					Lying				
g train of thought					Soiling/Wetting				
Mood swings					Easily Distracted				
Disorganized					Memories of trauma				
Anorexia					Hopelessness				
ocial Isolation					Poor grades /problems at school				
Grief					Panic Attacks				
Phobia's					Suicidal thoughts				
sical complaints					Feel panicky/anxious				
ing/ being bullied					Problems with parent				
blems at home					Attempted suicide in the past				

Briefly describe how the above symptoms impair your child's ability to function:

_____
_____
_____
_____
_____
_____