

Cynthia White Meyer, LICSW

7260 University Avenue NE Suite 315

Fridley, Minnesota 55432

(651) 307-4899

CWMeyerLICSW@gmail.com

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? _____		
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 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) _____

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Spiritual beliefs/practices: _____

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

Symptom	None	Mild	Moderate	Severe	Symptom	None	Mild	Moderate	Severe
Depressed Mood					Increased/decreased appetite				
Low Energy					Unplanned weight gain or loss				
Dep disturbance					Cruelty to animals				
Dissociation					Paranoid thoughts				
Hyperactivity					Poor concentration or Indecisive				
Bingeing					Purging / Over-exercising				
Nightmares					Excessive worrying				
Unresolved guilt					Impulsive actions/speech				
Irritability					Anger management problems				
Stomach/Acid indigestion					Vandalism / stealing				
Social Anxiety					Hallucinations				
Self-harm/mutilation/cutting					Racing thoughts				
Low self worth					Restlessness				
Nightmares					Loss of interest in normal activity				
Truancy (skipping school)					Lying				
Long train of thought					Soiling/Wetting				
Mood swings					Easily Distracted				
Disorganized					Memories of trauma				
Anorexia					Hopelessness				
Social Isolation					Poor grades /problems at school				
Grief					Panic Attacks				
Phobias					Suicidal thoughts				
Physical complaints					Feel panicky/anxious				
Being teased/bullied					Problems with parent				
Problems at home					Attempted suicide in the past				

Severe: Profound impact on quality of life and/or day to day functioning

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