

Jennifer Chen Speckman, LCSW

License #23659

CHILD/ ADOLESCENT CLIENT INFORMATION FORM

Client Name: _____

Today's Date: _____ Date of Birth: _____ Age: _____

Address: _____

Phone (H): _____ Phone (C): _____ Message ok? _____

Parent/Guardian: _____

Relationship: _____ Date of Birth: _____ Age: _____

Address: _____

Home Phone: _____ Work Phone: _____

Other Phone: _____ Message ok? _____

Parent/Guardian: _____

Relationship: _____ Date of Birth: _____ Age: _____

Address: _____

Home Phone: _____ Work Phone: _____

Other Phone: _____ Message ok? _____

Legal custody arrangement (Joint Legal? Or Sole Custody or no formal custody arrangement):

School: _____ Grade: _____

Primary Care Physician: _____

Phone: _____

Psychiatrist: _____ Phone: _____

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Health Conditions/ Significant Illnesses: _____

_____ Medications: _____

Prior Neuropsych Testing (include date)? Y or N

History of: ☐ ADD/ADHD ☐ Alcohol/ Substance Abuse ☐ Anxiety ☐ Behavior Problems

☐ Domestic Violence ☐ Depression ☐ Eating Disorders ☐ Emotional/Verbal Abuse

☐ Foster Placement ☐ Physical Abuse ☐ Sexual Abuse ☐ Other: _____

Previous Therapy/Mental Health Treatment:

Reasons for seeking services:

Emergency Contact: _____

Phone: _____