

SONYA L. FONTAINE LPC, PLLC
MINOR CLIENT INFORMATION QUESTIONNAIRE

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Date: _____

CHILD / TEEN INFORMATION

Name (first, middle initial, last): _____

Preferred name: _____

Date of birth: _____ Age: _____ Sex: _____

Street address: _____ Apt. #: _____

City: _____ State: _____ ZIP: _____

Youth phone (if applicable): _____ School / grade: _____

Completed by: _____ Relationship: _____

PARENT / GUARDIAN INFORMATION

Parent / guardian 1 name: _____ Relationship: _____

Phone: _____ Email: _____

Address (if different): _____

Parent / guardian 2 name: _____ Relationship: _____

Phone: _____ Email: _____

Address (if different): _____

Preferred contact: ☐ Parent / guardian 1 ☐ Parent / guardian 2 ☐ Other

Contact permissions: ☐ Calls ☐ Voicemail ☐ Scheduling texts ☐ Email

Safe contact instructions: _____

Emergency contact / relationship: _____ Phone: _____

CUSTODY AND AUTHORITY TO CONSENT

Child lives with: ☐ Parent(s) ☐ Guardian ☐ Foster / kinship caregiver ☐ Other

Person(s) authorized to consent to treatment: _____

Custody / guardianship arrangement and any contact restrictions:

Relevant court orders, guardianship or placement documents available:

Please provide relevant documents for review. This questionnaire is not consent to treatment.

FAMILY AND REFERRAL INFORMATION

Household members / siblings (names, ages and relationship to child):

Family circumstances: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Years married / date of separation, divorce or loss: _____

Significant family changes, transitions or losses (include dates / age of child):

Referral source: _____

SCHOOL AND DEVELOPMENT

School: _____ Grade: _____

School support: ☐ IEP ☐ 504 plan ☐ Other ☐ None ☐ Unsure

Learning, attention, attendance, behavior or peer concerns:

Developmental concerns / milestones or prior evaluations:

HEALTH INFORMATION

Pediatrician / primary care physician: _____ Phone: _____

Last visit: _____

Current medications and reason for taking each:

Allergies, major illnesses, surgeries or other medical concerns:

CURRENT CONCERNS AND HISTORY

Mark Current and/or Past. For past concerns, enter the date or approximate year.

MOOD / DEPRESSION				ANXIETY SYMPTOMS				OTHER CONCERNS / HISTORY			
Concern	Current	Past	Date	Concern	Current	Past	Date	Concern	Current	Past	Date
Depression / sadness	☐	☐	_____	Anxiety / persistent worry	☐	☐	_____	Loss of a parent	☐	☐	_____
Loss of interest	☐	☐	_____	Obsessive thinking	☐	☐	_____	Loss of a caregiver	☐	☐	_____
Loss of pleasure in activities	☐	☐	_____	Obsessive behaviors	☐	☐	_____	Other major loss	☐	☐	_____
Loss of motivation	☐	☐	_____	Agitation / irritability	☐	☐	_____	Domestic abuse	☐	☐	_____
Change in sleep	☐	☐	_____	Social isolation	☐	☐	_____	Sexual abuse	☐	☐	_____
Change in appetite	☐	☐	_____	Panic attacks	☐	☐	_____	Physical abuse	☐	☐	_____
Change in energy level	☐	☐	_____					Parents separated / divorced	☐	☐	_____
Frequent crying	☐	☐	_____					Bullying / peer conflict	☐	☐	_____
								Substance use / addiction	☐	☐	_____
								Behavior / anger concerns	☐	☐	_____
								Eating disorder	☐	☐	_____

Suicidal thoughts: ☐ No ☐ Yes ☐ Current ☐ Past

Frequency: _____ When: _____

Self-harm: ☐ No ☐ Yes ☐ Current ☐ Past

Frequency: _____ When: _____

Suicide attempt - Date: _____

Hospitalized? ☐ Yes ☐ No

Previously consulted a counselor or psychiatrist? ☐ Yes ☐ No

Date	Problem addressed	Counselor
_____	_____	_____
_____	_____	_____

REASONS FOR THERAPY AND GOALS

Parent / guardian: What brings your child to counseling? When did concerns begin?

What has helped or not helped? What changes would you like to see?

Child / teen: What would you like help with? What would make things better?

Strengths, interests, supportive people and activities your child enjoys:

Other information you would like Sonya to know (including cultural or faith preferences):

Prayer in sessions (optional): ☐ Yes ☐ No ☐ Discuss first

Completed by / relationship: _____

Signature: _____ Date: _____

Counseling consent, privacy practices and confidentiality will be reviewed separately.