



Youth – Client Information Sheet

Client Name: _____ Date of Birth: _____

Address: _____

Phone with area code: Home: _____ Cell: _____

Parent/Guardian #1 Name: _____ Date of Birth: _____

Address: _____

Email: _____

Employer / Position: _____

Phone with area code: Home: _____ Cell: _____

Parent/Guardian #2 Name: _____ Date of Birth: _____

Address: _____

Phone with area code: Home: _____ Cell: _____

Employer / Position: _____

Email: _____

Youth Current School: _____ Grade: _____

Pediatrician Name and Number: _____

Names and Ages of Children in the Home: _____

How did you learn about Royalton Psychological Associates: _____

Emergency Contact: Name: _____ Phone: _____

What brings you to Royalton Psychological Associates?

Client Name: _____

Please list any current medications:

Medication	Dosage	Prescriber	When began?

Please list any current or past health problems, operations, and hospitalizations:

Please provide the names of past mental health providers and dates of treatment:

Please list any developmental concerns you might have about the youth:

Please list any substance such as tobacco, alcohol, marijuana, pain medication, etc. the youth has used or is currently using: _____

Please list the youth's interests and what he/she takes pride in: _____

Please indicate if the youth is currently having any of the following issues or has experienced these issues in the past:

Concern:	Currently:	In the past:
Thoughts of hurting or killing self		
Thoughts of hurting or killing someone else		
Experienced a traumatic event		
Loss of a loved one		
Physically abused		
Sexually abused		
Neglected		
Difficulty falling or staying asleep		
Irritable / cranky		
Frequent crying		
Complains of being tired		
Daily sadness for more than 2 weeks		
Says negative things about self		
Worries too much		
Difficulty separating from caregiver		
Somatic / bodily complaints		
Startles easily		
Uncomfortable meeting new people		
Excessive fears		
Nightmares		
“Anxiety attacks”		
Obsessed with something		
Compulsions / ritualistic behaviors		
Frequent mood swings		
Racing thoughts		
Problems sustaining attention		
Disorganized		
Loses things		
Easily distracted		
Decrease in academic performance		
Fidgets / squirms in seat		
Talks excessively		
Impulsive		
Physically hurts other people		
Frequently argues with adults		
Refuses to follow instructions		
Misses or is late to school		
Breaks objects on purpose		
Has made self vomit to lose weight		
Worries something is wrong with their body		
Binges on food		
Other:		