the inner shine clinic

THE INNER SHINE CLINIC CLIENT INFORMATION FORM - CHILD & ADOLESCENT

CONFIDENTIAL

NAME: _____ DOB: _____ GENDER:_____

PARENT/GUARDIANS NAME: _____

PHONE: _____

FAMILY NUMBER TO CONTACT IN CASE OF EMERGENCY: _____

DO YOU GIVE CONSENT FOR THE INNER SHINE CLINIC TO LEAVE YOU A MESSAGE OR TEXT ON THIS NUMBER? : YES/NO

EMAIL: _____

ADDRESS: _____

_____

How did you find out about the Inner Shine Clinic: _____

_____

Do you have any health conditions: _____

_____

Are you currently taking any medications or supplements? : YES/NO

If so what are you taking and what for?_____

_____

Are you currently under the treatment of a psychiatrist, psychologist or doctor? _____

Any other health care professional you are seeing eg. Chiropractor, Therapist? _____

Physiotherapist, Dietician? _____

In your own words, briefly describe the main problem that prompted you to seek Integrative Counselling/Wellbeing Coaching or EFT at this time:

_____

_____

Any other current challenges in your life we should be aware of: _____

_____

_____

Strengths and resources that support you when times are challenging: _____

_____

_____

DEVELOPMENTAL HISTORY:

Were there any problems or complications during the pregnancy or delivery of the child/teen? If so please describe them: _____

_____

Did your child have any delays in reaching developmental milestones? If so please describe them: _____

_____

FAMILY HISTORY:

The names of the child's/teen's parents: _____

Any current legal issues or guardianship issues? _____

Who does your child/teen currently live with? _____

Who are significant people in your child's life that do NOT live with him/her? _____

_____

Has anyone in your family ever been diagnosed with a mental health disorder or has experienced mental health challenges? _____

_____

If yes, what relation are they to your child and what was their identified mental health diagnosis? _____

_____

Any history of traumatic events or abuse? _____

Any major life transitions (death, separation, moving to a new place, divorce, chronic illness, new school): _____

_____

PROBLEMS AREAS: IN THE FOLLOWING LIST, PLACE A CHECK MARK NEXT TO EACH ITEM THAT IDENTIFIES AN AREA OF CONCERN TO YOU.

__ ANGER

__ SLEEP PROBLEMS/NIGHTMARES

__ CANNOT CONCENTRATE

__ STRESSED/OVERWHELMED

__ ANXIETY OR PANIC ATTACKS

__ DEPRESSION

__ TROUBLE MAKING DECISIONS

__ UNABLE TO RELAX

__ WEIGHT/BODY ISSUES

__ UNHAPPY MOST OF THE TIME

__ PROBLEMS WITH SOCIAL RELATIONSHIPS (FRIENDS, BOYFRIEND/GIRLFRIEND)

__ USE OF ALCOHOL/DRUGS TO HELP UNWIND (TEENS)

__ PROBLEMS WITH FAMILY MEMBER USING ALCOHOL/DRUGS

__ PROBLEMS WITH PARENTS

__ FEELINGS OF NOT BEING GOOD ENOUGH

__ FEARFULNESS

__ PHOBIAS

__ SCHOOL/STUDY WORKLOAD

__ LONELINESS

__ GRIEF/LOSS

__ PAST TRAUMA/PAINFUL MEMORY

__ SELF ESTEEM

__ EMOTIONAL A LOT (ANGER, RAGING, SAD, NUMB ETC)

__ THOUGHTS OF HARMING YOURSELF

__ CHRONIC PAIN

__ OTHER (SPECIFY)

_____

_____

If you could wave a magic wand and make a problem disappear, what would you make disappear and what would be different?

_____

_____

Who are you closest to? _____

_____

What are your main strengths? _____

_____

What are your main areas of weakness? _____

_____

Anything else you would like us to know about you? _____

_____

What goals do you have for your child as he/she grows into an adult? If child filling in, what goals do you have for yourself? _____

_____

_____

How do you thinking coaching or counselling will help you? _____

_____

I UNDERSTAND THAT IT IS IMPORTANT TO PROVIDE ACCURATE INFORMATION IN ORDER TO TAILOR ASSESSMENT AND SESSIONS TO MEET MY CHILD'S NEEDS. THIS INFORMATION IS CORRECT, AS I HAVE DESCRIBED IT.

CAREGIVER SIGNATURE: _____ Date: _____

TEEN'S SIGNATURE: _____