RACHEL BENSON
LCSW

Rachel Benson, Licensed Clinical Social Worker, Inc.
Individual, Couples, & Group Psychotherapy

Client Information Sheet Minors (Under 18 years old)

The information requested on this form is confidential.
Please complete this form and bring it to your first session.

Today's Date: _____

PERSONAL

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone numbers: home:_____ cell:_____ work _____

Is it okay to leave confidential messages at the above numbers? Yes No (circle one)

Birthdate: _____ Age: _____ Gender: ___Maile ___Female

Email Address: _____
May I email you? ____Yes ____ No ***Please note: Email is not considered to be a confidential medium of communication.

Parent/Guardian 1:
Relationship to Client: _____

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone numbers: home:_____ cell:_____ work _____

Is it okay to leave confidential messages at the above numbers? Yes No (circle one)

Birthdate: _____ Age: _____ Gender: ___Maile ___Female

Email Address: _____
May I email you? ____Yes ____ No ***Please note: Email is not considered to be a confidential medium of communication.

Employer: _____ Occupation: _____

Parent/Guardian 2:
Relationship to Client: _____

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone numbers: home:_____ cell:_____work _____

Is it okay to leave confidential messages at the above numbers? Yes No (circle one)

Birthdate: _____ Age: _____ Gender: ___Maile ___Female

Email Address: _____
May I email you? ____Yes ____ No ***Please note: Email is not considered to be a confidential medium of communication.

Employer: _____ Occupation: _____

CLIENT INFORMATION

FAMILY

Father: ___Living ___Deceased Current age or age at time of death: ____ Cause of death: _____

Mother: ___Living ___Deceased Current age or age at time of death: ____ Cause of death: _____

Siblings? – How many _____ Names & Ages_____

What is the marital status of your parents? Never Married Married Separated Divorced Widowed
If never married, separated, or divorced, what is the custody arrangement?

_____

SPIRITUALITY
Do you consider yourself to be spiritual and/or religious? Yes No (Circle one)
If yes, describe your faith or belief:

_____

IN CASE OF EMERGENCY,
PLEASE CONTACT: _____ ***PHONE:*** _____
Name and relationship

PSYCHOTHERAPY, MEDICAL, AND MEDICATION HISTORY

Have you ever sought psychotherapy or counseling before? Yes No (circle one)

If so, when? _____ For how long? _____

Please list all medications you are currently using: _____

_____

Apart from those medications listed on the previous page, have you ever used any of the following:

Anti-depressants	Yes No (circle one)	Anti-anxiety meds	Yes No
Appetite suppressants	Yes No	Laxatives	Yes No
Sedatives	Yes No	Muscle relaxants	Yes No
Pain medication	Yes No		

Have you ever been hospitalized for any reason? Yes No (circle one)

If so, when? _____ For how long? _____

If so, please explain the situation: _____

Do you have any current or past medical issues? Yes No (circle one)

If yes, please explain: _____

Are you currently experiencing overwhelming sadness, grief, or depression? Yes No

Are you currently experiencing anxiety, panic attacks, or have any phobias? Yes No

Do you drink alcohol more than once a week? Yes No

How often do you engage in recreational drug use? Daily Weekly Monthly Infrequently Never

EMPLOYMENT

Employer: _____ Occupation: _____

Employment address: _____

ADDITIONAL INFORMATION

Are you currently in a romantic relationship? Yes No
If yes, how long have you been in this relationship? _____

What activities do you enjoy doing?

_____

What significant life changes or stressful events have you experienced recently?

_____

_____

What would you like to accomplish out of your time in therapy?

_____

_____

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CANCELLATION POLICY

To avoid being charged for a cancelled session, the session must be cancelled at least 24 hours in advance by leaving a message at (714)-468-3685. Sessions cancelled with less than 24 hours notice will be charged at the full fee. By law, insurance providers may not reimburse patients for fees paid for cancelled sessions.

POLICY AND LAWS REGARDING CONFIDENTIALITY

All information between patient and therapist is held in strict confidence. The only exception to this is that state law requires all mental health providers to report suspected child or elder abuse, and allows for breach of confidentiality if patients disclose a likelihood to be of danger to themselves or others.

I have read the foregoing and my signature below attests to my understanding of these policies.

Signature **Date**

Parent/Guardian 1 Signature **Date**

Parent/Guardian 2 Signature **Date**