COMMUNITY INSTITUTE FOR PSYCHOTHERAPY

CHILD CLIENT INFORMATION — INITIAL

This section to be filled out by THERAPIST:

Client # _____ **Today's Date** _____

Intern Therapist/Licensed Therapist _____

Supervisor _____

Referral Source

- ☐ a. Another Client
- ☐ b. Another Person/Friend
- ☐ c. Brochure
- ☐ d. Catholic Charities
- ☐ e. Doctor/Kaiser
- ☐ f. Family Service Agency
- ☐ g. Homeward Bound
- ☐ h. Internet
- ☐ i. MAWS
- ☐ j. Marin IJ
- ☐ k. Media or Event
- ☐ l. MSPC
- ☐ m. Other Agency
- ☐ n. Pacific Sun
- ☐ o. Phone Book
- ☐ p. Probation Dept
- ☐ q. Psychotherapist
- ☐ r. Schools Project
- ☐ s. Yellow Pages/other advertising

Name of referral source:_____

TO BE FILLED OUT BY PARENT OR GUARDIAN

Please fill out one form for each individual seen in individual, couples, or family therapy:

Child's Legal Name

_____
Last First Middle Initial

Address_____
Street

_____
City State Zip

Residence

- ☐ a. Central Marin/San Rafael
- ☐ b. North Marin County
- ☐ c. South Marin County
- ☐ d. West Marin County
- ☐ e. East Bay
- ☐ f. San Francisco
- ☐ g. Sonoma County
- ☐ h. Unknown or Other

Phone: Home Ph: _____ **Emergency Contact Name**_____

Work Ph: _____ **Emergency Contact Relation**_____

Cell Ph: _____ **Emergency Contact Phone Number**_____

Email: _____

Medi-Cal or Beacon Number _____

Date of Birth ____ / ____ /_____
m d y

Age _____

Gender ☐ Male ☐ Female ☐ FTM ☐ MTF ☐ Queer ☐ Non Binary ☐ Trans ☐ Genderfluid
☐ Unspecified ☐ Other

Sexual Orientation ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Heterosexual ☐ Queer ☐ Questioning ☐ Unspecified
☐ Other

Pronouns you use ☐ she/her/hers ☐ he/him/his ☐ they/them/theirs ☐ other_____

Plan

☐ a. Medi-Cal #:_____
☐ b. Beacon
☐ c. Victim's Witness
☐ d. Blue Cross
☐ e. No Charge
☐ g. Other: _____

Education

☐ a. Preschool/elementary school
☐ b. Middle School
☐ c. Some High School
☐ d. Finished High School
☐ e. Some College
☐ f. Bachelor's Degree
☐ g. Some Graduate School
☐ h. Master's Degree
☐ i. Doctorate
☐ j. Trade School

Occupation

☐ a. Artist
☐ b. Civil service
☐ c. Clerical
☐ d. Construction
☐ e. Education
☐ f. Homemaker
☐ g. Industry
☐ h. Management
☐ i. Mechanical
☐ j. Professional
☐ k. Retail sales
☐ l. Sales
☐ m. Social services
☐ n. Student
☐ o. Transportation
☐ p. Other

Description of occupation: _____

Work Status

☐ a. Employed full time
☐ b. Employed part time
☐ c. Unemployed
☐ d. Not in job market
☐ e. Student

Gross Monthly Income

☐ a. $4,200 And Up
☐ b. $3,900 - $4,199
☐ c. $3,600 - $3,899
☐ d. $3,300 - $3,599
☐ e. $3,000 - $3,299
☐ f. $2,700 - $2,999
☐ g. $2,400 - $2,699
☐ h. $2,100 - $2,399
☐ i. $1,800 - $2,099
☐ j. $1,500 - $1,799
☐ k. $1,200 - $1,499
☐ l. $0 - $1,199

Marital Status (list one only)

☐ a. Never Married
☐ b. Now Married
☐ c. Domestic Partner
☐ d. Separated
☐ e. Divorced
☐ f. Widowed

Ethnicity

☐ a. Asian/Pacific Islander
☐ b. Bi-racial/Multi-racial
☐ c. African American/Black
☐ d. Caucasian
☐ e. Latinx
☐ f. Native American
☐ g. Unknown
☐ h. Other_____

Spiritual/Religious Orientation

☐ a. Muslim
☐ b. Jewish
☐ c. Buddhist
☐ i. Taoist
☐ j. Sikh
☐ k. Agnostic

☐ d. Christian
☐ e. Hindu
☐ f. Pagan
☐ g. Shamanism
☐ h. Jain
☐ l. Spiritual but not religious
☐ m. Atheist
☐ n. Unknown

Client Category (To be filled out by therapist) _____

Number of People in Household (including self) _____

Single Parent

☐ a. yes ☐ b. no

Suicidal Assessment — Child

Current	**Past**
☐ a. None	☐ a. Past ideation _____
☐ b. Current ideation/thoughts _____	☐ b. Past attempts _____
☐ c. Plan _____	☐ c. Past threats _____

Suicidal Assessment — Family

Current	**Past**
☐ a. None	☐ a. Past ideation _____
☐ b. Current ideation/thoughts _____	☐ b. Past attempts _____
☐ c. Plan _____	☐ c. Past threats _____

PSYCHOLOGICAL/PSYCHIATRIC HISTORY

Previous Therapy (Number of different therapies) _____**Psychiatric Hospital Stays (Number)**_____

Chemical Dependence In-Patient Stays (Number) _____

History of Psychotropic Medications

☐ a. yes ☐ b. no

Currently Using Psychotropic Medications

☐ a. yes ☐ b. no

Name of drugs:_____

Frequency of Contact (Number of sessions weekly) _____
(To be filled out by therapist)

Service Unit

☐ a. individual counseling
☐ b. couple counseling
☐ c. family counseling
☐ d. support group

Chronic Physical Disease? _____

Chronic Physical Disabilities? _____

Please check as many CONDITIONS as you feel apply to your child. (Please number top five.)

CONDITIONS

☐ Adjustment
☐ Mental/Developmentally Disabled

- ☐ Alzheimer's/ Dementia
- ☐ Anger/ Aggression/ Bullying
- ☐ Anxiety
- ☐ Attention Deficit/Hyperactivity Issues
- ☐ Borderline Personality
- ☐ Chemical Dependency - Alcohol
- ☐ Chemical Dependency - Drugs
- ☐ Chronic Pain
- ☐ Chronic Medical Condition
- ☐ Co-Dependency
- ☐ Dependent/ Independence Issues
- ☐ Depression
- ☐ Disabled
- ☐ Eating Disorders
- ☐ Enuresis (Bedwetting)
- ☐ Gender Identity Issues
- ☐ Grief / Loss
- ☐ Health / Medical Problems
- ☐ HIV Positive Person
- ☐ Identity Crisis
- ☐ Irrational Fears
- ☐ Parental Stress
- ☐ Person W/ AIDS
- ☐ Personality Disorder
- ☐ Physically Abused
- ☐ Psychologically Abused
- ☐ Psychosis
- ☐ Post Traumatic Stress Disorder
- ☐ Runaway Youth
- ☐ Self Injury
- ☐ Separation Anxiety
- ☐ Sexually Abused
- ☐ Sexual Identity Issues
- ☐ Sexual Frustration
- ☐ Stroke
- ☐ Suicide Ideations/ Thoughts
- ☐ Suicide Attempts
- ☐ Trichotillomania (pulling, twisting, biting hair)
- ☐ Temper Tantrums
- ☐ Victim Of Natural Disaster
- ☐ Work Related Stress
- ☐ Memory Loss

Please check as many ISSUES as you feel apply to your child. (Please number top five.)

ISSUES

- ☐ Abandonment
- ☐ Abortion Issues
- ☐ Adult Child Of Alcoholic
- ☐ Aging
- ☐ Court Ordered
- ☐ Crisis Management
- ☐ Cultural Adjustment
- ☐ Custody Dispute
- ☐ Deaf/ Hard of Hearing
- ☐ Delinquency / Criminality
- ☐ Divorce / Separation
- ☐ Domestic Violence
- ☐ Employment
- ☐ Ethnic/Racial Discrimination
- ☐ Ex-Offender
- ☐ Family Crisis
- ☐ Financial Stress
- ☐ Foster Care
- ☐ Housing Crisis
- ☐ Homeless/ Transitional Housing
- ☐ Illiterate
- ☐ Immigrant / Refugee
- ☐ Incarceration
- ☐ Pregnant/Parenting Teen
- ☐ Rape/ Sexual Assault
- ☐ Relationship / Interpersonal
- ☐ Separation/Divorce
- ☐ Single Parent
- ☐ Spiritual Issues
- ☐ Social Difficulties
- ☐ Social Isolation
- ☐ Step Family Issues
- ☐ Unemployed
- ☐ Unstable Employment
- ☐ Veteran
- ☐ Violence
- ☐ Visually Impaired

FINANCIAL INFORMATION

Client Name _____ Date _____

Intern-Therapist _____

IDENTIFYING INFORMATION

Marital Status _____ (M, S, D, W, domestic partner)

Number in household _____

INCOME DATA

Gross Monthly Earnings _____

Self _____

Spouse _____

Other _____

Support Payments Received _____

Social Security, Pensions _____

Interest, Dividends, etc. _____
Other (specify) _____
(rental income, food stamps, etc.)
TOTAL GROSS MONTHLY INCOME* _____
*Income verification may be requested. Please indicate type of verification available — i.e., income tax statements, pay stubs, etc. _____

FEE
Based on CIP's sliding fee scale, your fee is $ _____

_____ _____
Client's Signature Date Student Therapist Date