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YOUTH GUARDIAN FORM Today's Date: ___/___/_____

The following information should be completed by the minor's legal guardian.

The information you provide will be kept confidential as outlined in the *Notice of Provider Privacy Practices*, which reflects state and federal regulations. Feel free to add any other information you feel may be useful. Please contact me with any concerns prior to completing this questionnaire or ask questions at any point in our work.

Client Information:

Name: _____ DOB: ___/___/_____ Age: _____
(Last) (First) (Middle)

School: _____ Grade: _____

Please list everyone who lives in the home with the client including their name, age, and relationship to client.

_____

_____

Parent/Guardian Information:

Name: _____ DOB: ___/___/_____ Age: _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Cell Phone: _____ May I leave you a message? ☐Yes ☐No

May I text message you to coordinate appointments? ☐Yes ☐No

Email: _____ May I email you? ☐Yes ☐No

Calls or emails will be discreet, but please indicate any restrictions: _____

Employer & Occupations: _____

History of Client's Care:

Please list any medications the client is currently taking (name, dosage, prescriber, and reason for medication):

_____

_____

Please list any mental health care the client has received previously, including inpatient care or hospitalization for psychiatric reasons (name of practitioner and dates of care).

_____

_____

Please list any mental health diagnosis or learning disabilities which the client has been diagnosed.

_____

_____

Please list any significant physical illnesses, injuries, or surgeries that the client has experienced or is currently experiencing. _____

_____

_____

Is the client under a physician's care? ☐ Yes ☐ No Name & Phone number: _____

Is the client under a dietitian's care? ☐ Yes ☐ No Name & Phone number: _____
Is the client under a psychiatrist's care? ☐ Yes ☐ No Name & Phone number: _____

Family Mental Health History

In the section below, please identify if there is a family history of any of the following.

Alcohol/Substance Use ☐ No ☐ Yes Relationship to family: _____
Anxiety ☐ No ☐ Yes Relationship to family: _____
Bipolar/Manic-Depressive ☐ No ☐ Yes Relationship to family: _____
Depression ☐ No ☐ Yes Relationship to family: _____
Domestic Violence ☐ No ☐ Yes Relationship to family: _____
Obsessive Compulsive Behavior ☐ No ☐ Yes Relationship to family: _____
Schizophrenia ☐ No ☐ Yes Relationship to family: _____
Suicide/Suicide Attempts ☐ No ☐ Yes Relationship to family: _____

Caregiver Observations

Please circle all of the following you have observed in your child.

Decrease appetite	Decreased appetite	Throwing up after eating	Refusing to eat
Nightmares	Difficulty falling asleep	Difficulty staying asleep	Sleeping during the day
Headaches	Stomachaches	Aches and pains	Fatigue
Picking at skin/nails	Pulling out hair/lashes	Chewing lips/fingers	Cutting/burning self
_____	_____	_____	_____

Please indicate, to the best of your knowledge, if the client has used any of the following.

Alcohol ☐ Never Used ☐ Currently Using ☐ Previously Used Amount if using _____
Marijuana ☐ Never Used ☐ Currently Using ☐ Previously Used Amount if using _____
Cocaine/Crack ☐ Never Used ☐ Currently Using ☐ Previously Used Amount if using _____
Heroin/Narcotics ☐ Never Used ☐ Currently Using ☐ Previously Used Amount if using _____
Amphetamines ☐ Never Used ☐ Currently Using ☐ Previously Used Amount if using _____
Depressants ☐ Never Used ☐ Currently Using ☐ Previously Used Amount if using _____
PCP ☐ Never Used ☐ Currently Using ☐ Previously Used Amount if using _____
LSD ☐ Never Used ☐ Currently Using ☐ Previously Used Amount if using _____
Inhalants ☐ Never Used ☐ Currently Using ☐ Previously Used Amount if using _____
Tobacco/Nicotine ☐ Never Used ☐ Currently Using ☐ Previously Used Amount if using _____
Caffeine ☐ Never Used ☐ Currently Using ☐ Previously Used Amount if using _____
Other_____ ☐ Never Used ☐ Currently Using ☐ Previously Used Amount if using _____

How is your sleep? ☐ Good ☐ Poor How many hours do you sleep per night? _____
How is your diet? ☐ Good ☐ Poor How many meals do you eat per day? _____
Do you exercise regularly? ☐ Yes ☐ No How many times per week? _____
Do you drink alcohol or use drugs? ☐ Yes ☐ No What, how much, and how often? _____
_____

Additional Information:

What significant life changes or stressful events has the client experienced recently? _____
_____
_____
_____

What do you consider some of the client's strengths? _____
_____
_____
_____

What do you consider to be some of the client's struggles? _____
_____
_____
_____

What would you like the client to accomplish out of his/her time in therapy? _____
_____
_____
_____

Legal Guardian Signature: _____ Date: _____