Dawn S. Dilley Ph.D. HSPP
Clinical Health Psychologist

Minor Client Information

Preferred Name: _____ Today's Date: _____

Legal Name: _____ Pronouns: _____

Date Of Birth: _____ Age: _____ Place Of Birth: _____

Address: _____
Street Address City State ZIP

Parent/Guardian Name 1: _____
Phone Phone Number: _____ Date of Birth _____
Address if different than child:_____

Parent/Guardian Name 2: _____
Phone Phone Number: _____ Date of Birth _____
Address if different than child: _____

Parent/Guardian Name 3: _____
Phone Phone Number: _____ Date of Birth _____
Address if different than child: _____

Emergency Contact (name and #): _____

With whom does the child live and when? _____

School: _____ Grade/Year: _____

Job: _____

Extracurriculars: _____

Who lives in the house with child (relationship and age): _____
_____

Other immediate family that child does not live with: _____
_____

Name of Primary Care Physician: _____

Name of Psychiatrist, If Any: _____

Name of Past Psychotherapist(s): _____
_____

Birth Information:
Was child adopted? Yes _____ No _____

Birth story (surrogate, IV, vaginal or cesarian delivery, home delivery, inducing, time in labor, time in hospital or recovery, first two weeks, etc.): _____
_____
_____
_____

Development:
Did child reach developmental milestones? _____
_____
_____
_____

History of Mental Health: _____
_____
_____

Strengths: _____
_____
_____

Major life events: _____
_____
_____

What would you like to address in therapy? _____
_____
_____
_____
_____

How does the child identify (ex. boy, transgender female, black, Catholic, 7th grader, disabled):
_____
_____

Allergies: _____