



Jane F. Hamilton, Ph.D.

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MINOR CLIENT INFORMATION

Today's Date _____

Name of minor _____ Date of Birth _____

Address _____

Name of Mother _____ Phone _____

Name of Father _____ Phone _____

Divorced? Yes / No

Separated? Yes / No

Name(s) of sibling(s)

Birthdate(s) of siblings

Name of school _____ Current grade _____

Name of Family Physician _____ Phone _____

How did you hear about us? _____

Reason for your visit today _____

Have you previously consulted with another provider for this complaint? _____

In case of an emergency, who should we contact? _____



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SYMPTOM QUESTIONNAIRE

Are you aware of the minor experiencing any of the following?

Nausea or vomiting	Yes	No
Stomach aches	Yes	No
Concussion or other head injury	Yes	No
Recent weight or appetite change	Yes	No
Difficulties breathing	Yes	No
Intrusive thoughts	Yes	No
Changes in vision	Yes	No
Blackouts or memory loss	Yes	No
Dizziness or loss of balance	Yes	No
Headaches	Yes	No
Difficulty with coordination	Yes	No
Feeling fatigued or ill	Yes	No
Change in sleep pattern	Yes	No
Laughing or crying for no apparent reason	Yes	No
Cravings for sweet/salty foods	Yes	No
Alcohol use	Yes	No
Recreational drug use	Yes	No
Use of tobacco products (including vaping)	Yes	No
Does the minor seem anxious?	Yes	No
Does the minor seem depressed?	Yes	No

Any other symptoms that concern you: _____



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Please list all current non-prescription and prescription medications and dosages: _____

Please list any medical issues: _____

On a scale of 1 to 5 (1 being dissatisfied - 5 being satisfied) please rate the following areas of the minor's life.

	Least Satisfied					Most Satisfied
	1	2	3	4	5	
Emotions	1	2	3	4	5	
Mental Health	1	2	3	4	5	
Family Life	1	2	3	4	5	
Personal Relationships (including friends)	1	2	3	4	5	
Physical Health	1	2	3	4	5	
Social Life	1	2	3	4	5	
School Functioning	1	2	3	4	5	



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Please describe the current situation: _____

Feel free to continue on the backside of the paper