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Omega Youth Empowerment, PLLC

**CONFIDENTIAL INFORMATION FORM for a MINOR**

To be completed by the adolescent or the parent of a minor child

Name Date

Date of Birth Age Male \_\_\_\_\_ Female \_\_\_\_\_

Please complete the following information for your minor. All information is for the sole purpose of counseling and will remain confidential.

**MEDICAL HISTORY**

Name of Primary Care Physician   
Physician’s Address Phone

Name of Psychiatrist   
Psychiatrist’s Address Phone

Current Medications being taken:  
1) Dosage/Freq Purpose   
2) Dosage/Freq Purpose   
3) Dosage/Freq Purpose   
4) Dosage/Freq Purpose

Date of last psychiatric evaluation Date of next apt

Has your minor ever been hospitalized for medical or psychiatric reasons? YES NO  
Hospital Mo/Yr Reason

\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_

Describe any important medical history, chronic ailments, or other health concerns

Please indicate any close relatives who have experienced emotional/mental health challenges

**MENTAL STATUS**

If applicable, please list any previous mental health diagnosis that have been given to your minor:

Diagnosis Date