Jessica P. Harrell, Ph.D.
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Client Information and Background Form

Date: ______________________

*CHILD'S NAME: Last: ___________________________ First__________________________

Date of Birth: __________________________

Home Address: ____

____

Parent Contact Information:

*Mother's Name: ____

Primary Phone Number: ______________________________ cell/home/work (circle)

May I leave a message on this number? Yes/No (circle)

Secondary Phone Number: ______________________________ cell/home/work (circle)

May I leave a message on this number? Yes/No (circle)

Mother's Email: ____

*Father's Name: ____

Primary Phone Number: ______________________________ cell/home/work (circle)

May I leave a message on this number? Yes/No (circle)

Secondary Phone Number: ______________________________ cell/home/work (circle)

May I leave a message on this number? Yes/No (circle)

Father's Email: ____

Parents' Marital Status: Single ______ Married _______ Divorced _______ Other ___________

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Mother's Employment: Full-time ______ Part-time ______ Homemaker ______

Employer: __________________________________ Occupation:_________________________________

Length of employment: _______________________ Highest degree earned: _____________________

Father's Employment: Full-time ______ Part-time ______ Homemaker ______

Employer: __________________________________ Occupation:_________________________________

Length of employment: _______________________ Highest degree earned: _____________________

Pregnancy/Birth:

Height and weight at birth _____________________ Full-term? _____________________

Were there any complications or problems during pregnancy or delivery? Yes or No (circle)

If yes, explain: ____

Temperament as a baby: ____________________ Develop. milestones reached on time? _________

History of eating problems? ____________ History of sleeping problems? _______________________

History of speech/language problems? ________________

Health/Medical History:

Current medical conditions: No _______ Yes (what/when)____

Surgeries/Serious accidents: No _______ Yes (what/when)____

Has your child ever had a seizure? No _____ Yes _____ Does your child follow a special diet? No _____ Yes ____

Does your child smoke cigarettes? No _____ Yes ____ Does your child drink alcohol? No _____ Yes _____

Does your child use drugs? No ________ Yes _____ Has your child ever been arrested? No _____ Yes _____

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Is your child currently being treated by a psychiatrist? No _______ Yes _______

Name of psychiatrist ______________________________ Phone _______________________

Please list all medications your child is currently taking:

Medication: ______________________________________ Dosage: ____________________

Medication: ______________________________________ Dosage: ____________________

Medication: ______________________________________ Dosage: ____________________

Previous Psychological Treatment: None ________ Yes ________ (see below)

Outpatient Therapist: ____

When: ________________________ Reason for treatment: ________________________________

Other Outpatient Therapy: ____

Inpatient therapy (including substance abuse):

Where: ____ When: ________________________

Reason for admission: ____

Child's School Information:

School ________________________________ District __________________________

Current Grade _______ Teacher/Counselor ___________________________________

Has your child ever repeated a grade? _____ If yes, which grade? ________

Has your child ever received Special Education services? __________ When? _________________________

If yes, what type of services is he/she certified to receive? ____

Date of last IEP ________________________

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Child's Home Environment:

Please list all family members and persons living with your child:

Name: ___________________________________ Age: _____ Relationship to child: ________

Name: ___________________________________ Age: _____ Relationship to child: ________

Name: ___________________________________ Age: _____ Relationship to child: ________

Name: ___________________________________ Age: _____ Relationship to child: ________

Other family members NOT living with your child:

Name: ___________________________________ Age: _____ Relationship to child: ________

Name: ___________________________________ Age: _____ Relationship to child: ________

Family History of Psychiatric Illness and/or Substance Abuse:

Mother: _______________________________ Father: ________________________________

Siblings: _______________________________ Other: ________________________________

What approaches to discipline do you typically use with your child?

Please list your child's hobbies, sports, recreational activities and special skills or talents:

Please list specific concerns that you wish to address in the initial intake evaluation and any goals you have for your child in therapy:

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PLEASE CHECK ALL BEHAVIORS THAT APPLY TO YOUR CHILD:

______ Worries

______ Fears

______ Obsessive Thoughts

______ Compulsive Behavior

______ Nightmares/Night Terrors

______ Won't Sleep Alone

______ Insomnia

______ Misses School Due to Illness

______ Skips School

______ Runs Away

______ Legal Problems

______ Tantrums/Outbursts

______ Bullies

______ Defiant/Oppositional

______ Argues

______ Fights

______ Lies

______ Sets Fires

______ Destroys Property

______ Reckless/Careless

______ Disruptive

______ Messy

______ Accident Prone

______ Short Attention Span

______ Distractible

______ Impulsive

______ Hyperactive

______ Poor Schoolwork

______ Cruel to Animals

______ Mood Swings

______ Sadness Depression

______ Crying Spells

______ Irritable

______ Withdrawn

______ Boredom