

Patient Information

Date: _____

Name of Child: Last _____ First _____ Middle _____

Date of Birth: _____

Home Address: _____

Mother's Name: _____ Phone(s) _____

Home: _____

Work: _____

Cell: _____

Father's Name: _____ Phone(s) _____

Home: _____

Work: _____

Cell: _____

Referral source for appointment: _____

May I contact the referral source with my recommendations? Yes No N/A

Signature on File

I understand that I am responsible for my child's bill and that I will be asked to pay in full at the conclusion of each therapy session. I will be provided an invoice that I may submit to my insurance company for reimbursement.

Name (Print)

Signature Date

Person Reporting Information: Mother Father Other: _____

DEMOGRAPHIC INFORMATION:

Is the child adopted? No Yes: Age of child when adopted? _____

Parents' Marital Status: Married (month/year): _____ Divorced (month/year) _____

Separated (month/year) _____ Living Together (month/year) _____

Widowed (month/year) _____

If not married to each other, is either parent remarried?

Mother: No Yes (month/year) _____

Father: No Yes (month/year) _____

Father's
Employment:

Full Time Part Time Disabled Retired Homemaker

Employer _____ Phone Number _____

Occupation _____

Mother's
Employment:

Full Time Part Time Disabled Retired Homemaker

Employer _____ Phone Number _____

Occupation _____

Father's
Education:

Elementary High School GED Some College
 Trade Associates BA/BS Post Grad _____

Current Student _____ Year _____ Major _____

Full-Time Part-Time

Mother's
Education:

Elementary High School GED Some College
 Trade Associates BA/BS Post Grad _____

Current Student _____ Year _____ Major _____

Full-Time Part-Time

Please list all family members and persons living with patient:

Name	Relationship to Patient	Date of birth	Living with Patient?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

GENERAL BEHAVIOR:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Friendly, Outgoing | <input type="checkbox"/> Prefers Company | <input type="checkbox"/> Cooperative | <input type="checkbox"/> Respectful |
| <input type="checkbox"/> Shy | <input type="checkbox"/> Prefers being Alone | <input type="checkbox"/> Stubborn | <input type="checkbox"/> Defiant |
| <input type="checkbox"/> Easy-going, Calm | <input type="checkbox"/> Optimistic | <input type="checkbox"/> Confident | <input type="checkbox"/> Takes Risks |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Pessimistic | <input type="checkbox"/> Expects Failure | <input type="checkbox"/> Cautious |
| <input type="checkbox"/> Hardworking | <input type="checkbox"/> Caring | <input type="checkbox"/> Sharing | <input type="checkbox"/> Generally Happy |
| <input type="checkbox"/> Lazy | <input type="checkbox"/> Uncaring | <input type="checkbox"/> Selfish | <input type="checkbox"/> Generally Unhappy |

PROBLEM BEHAVIORS: (Current or Past)

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Worries | <input type="checkbox"/> Runs Away | <input type="checkbox"/> Reckless, Careless | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Fears | <input type="checkbox"/> Skipping School | <input type="checkbox"/> Disruptive | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Obsessive Thoughts | <input type="checkbox"/> Legal Problems | <input type="checkbox"/> Messy | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Compulsive Behavior | <input type="checkbox"/> Tantrums, Outbursts | <input type="checkbox"/> Accident Prone | <input type="checkbox"/> Crying Spells |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Bullies | <input type="checkbox"/> Short Attention Span | <input type="checkbox"/> Irritable |
| <input type="checkbox"/> Night Terrors | <input type="checkbox"/> Defiant/Oppositional | <input type="checkbox"/> Distractible | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Won't Sleep Alone | <input type="checkbox"/> Argues | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Boredom |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Fights | <input type="checkbox"/> Hyperactive | |
| <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Lies | <input type="checkbox"/> Poor Schoolwork | |
| <input type="checkbox"/> Misses School due to Illness | <input type="checkbox"/> Sets Fires | <input type="checkbox"/> Cruel to Animals | |
| | <input type="checkbox"/> Destroys Property | | |

DEVELOPMENTAL HISTORY:

Mother's Pregnancy: Normal Complicated (Explain) _____
 Planned Pregnancy

Substances used during pregnancy: None Tobacco Alcohol Drugs Medications

Birth: Full Term Premature _____ weeks C-Section Fetal Distress

Please explain any complications: _____

Child's Condition at Birth: Healthy Problems _____

Child's Birth Weight: _____ lbs. _____ oz.

As an infant, was child: Easy to Manage Irritable Demanding
 Alert/Responsive Poor Eater Poor Sleeper

Developmental Milestones: At what age did child:

Sit up unassisted _____ Walk without support _____ Use first words _____

Use sentences _____ Toilet trained for daytime _____ Dry at night: _____

Problems with any of above: _____

Concerns before kindergarten by teacher, physician, parent:

- None
- Language development (use of words)
- Speech development (pronunciation)
- Fine motor development (pencil grip, etc)
- Balance/Coordination
- Behavior problems
- Hearing
- Vision
- Intelligence

SCHOOL HISTORY: Not Applicable

Has child ever repeated a grade? No Yes If Yes, which grade(s)? _____

Has child ever been assessed for special education services? No Yes If Yes, when? _____

Has child ever been in Special Education? No Yes If Yes, when and what type of special education was he or she certified to receive? _____

SIGNIFICANT LIFE EVENTS:

Event	Age(s)	Event	Age(s)	Event	Age(s)
<input type="checkbox"/> Change of residence	_____	<input type="checkbox"/> Change of school	_____	<input type="checkbox"/> Change of custody	_____
<input type="checkbox"/> Marital conflict	_____	<input type="checkbox"/> Parents separated	_____	<input type="checkbox"/> Parents divorced	_____
<input type="checkbox"/> Visitation problems	_____	<input type="checkbox"/> Parent remarried	_____	<input type="checkbox"/> Stepparent conflict	_____
<input type="checkbox"/> Sibling birth	_____	<input type="checkbox"/> Economic problems	_____	<input type="checkbox"/> Illness in family	_____
<input type="checkbox"/> Suffered accident	_____	<input type="checkbox"/> Witnessed accident	_____	<input type="checkbox"/> Witnessed abuse	_____
<input type="checkbox"/> Victim of abuse	_____	<input type="checkbox"/> Severe fright/trauma	_____	<input type="checkbox"/> Death of loved one	_____
<input type="checkbox"/> Suicide of loved one	_____	<input type="checkbox"/> Death of pet	_____	<input type="checkbox"/> Other _____	_____

MEDICAL HISTORY:

Current Conditions/Allergies: No Yes: _____

Surgeries/Serious Accidents: No Yes: _____

Physician: _____ Phone Number: _____

PSYCHIATRIC TREATMENT:

Is your child currently being treated by a psychiatrist? No Yes (Please see below)

Name of psychiatrist: _____ Phone Number: _____

Please list all medications your child is currently taking (psychiatric and other): None

Medication: _____	Dosage: _____
Medication: _____	Dosage: _____
Medication: _____	Dosage: _____
Medication: _____	Dosage: _____
Medication: _____	Dosage: _____

Has your child been in therapy before? No Yes (Please see below)

Outpatient: Therapists/Dates: _____

Reason(s) for prior therapy: _____

Inpatient Psychiatry: Where/Dates: _____

Reason(s): _____

PSYCHIATRIC TREATMENT cont.

Inpatient Chemical Dependency: _____

Outpatient Chemical Dependency: _____

Current Alcohol Use: _____

Current Drug Use: _____

FAMILY HISTORY OF PSYCHIATRIC/SUBSTANCE ABUSE DISORDERS: None

	Mother	Father	Siblings	Grandparents/Aunts/Uncles
Alcohol Problems				
Drug Problems				
Anxiety				
Depression				
Suicide Attempts/Completed				
Schizophrenia				
Other				

CURRENT STRENGTHS/INTERESTS/HOBBIES:

REASON(S) FOR BRINGING CHILD IN FOR EVALUATION: (What are you concerned about?)
