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This Form is Completely Confidential

Today's date: _____

Your child's name: _____
Last First Middle Initial

Parent or Legal Guardian's Name: _____
Last First Middle Initial

Child's date of birth: _____ Gender: _____

Home street address: _____

City: _____ State: ___ Zip:_____

Parent or Legal Guardian's Name of Employer:_____

Address of Employer: _____

City: _____ State: ____Zip:_____

Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____
Calls will be discreet, but please indicate any restrictions:_____

Referred by:
_____
If referred by another clinician, would you like for us to communicate with one another?
☐ **Yes** ☐ **No**

Person(s) to notify in case of any emergency:
_____
Name Phone
I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature):_____

Credit Card to be kept on file:
Name as it appears on card:_____
CC#_____
Exp:_____

Please briefly describe your child's presenting concern(s):

What are your/your child's goals for therapy?

_____

_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)?_____

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses your child has had: _____

_____

_____

_____

Current Medications (if you need more room, please write on the back of this page):

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous medical hospitalizations (Approximate dates and reasons): _____

_____

_____

Previous psychiatric hospitalizations (Approximate dates and reasons): _____

_____

Has your child ever talked with a psychiatrist, psychologist, or other mental health professional? (If yes, please list approximate dates and reasons): _____

_____

_____

FAMILY:

How would you describe your child's relationship with his or her mother? _____

_____

_____

How would you describe your child's relationship with his or her father? _____

_____

_____

Are the child's parents still married or did they divorce?_____ If they divorced, how old was the child when the parents separated or divorced and how do you think this impacted him or her? _____

Please describe your child's relationship with his or her grandparents: _____
_____
_____

Were there any other primary care givers who have had a significant relationship with your child? If so, please describe how these people may have impacted your child's life: _____
_____
_____

How many sisters does your child have? _____Ages? _____

How many brothers does your child have? _____ Ages? _____

How would you describe your child's relationships with his or her siblings? _____
_____
_____
_____

SOCIAL SUPPORT, SELF-CARE, & EDUCATION:

POOR EXCELLENT

Child's current level of satisfaction with friends and social support: 1 2 3 4 5 6 7

How would you describe your child's relationships with his/her peers? _____
_____

Please briefly describe any history of abuse, neglect and/or trauma:
_____
_____
_____

Please briefly describe your child's self-care and coping skills:
_____

What are your child's diet, weight, and exercise/activity patterns?
_____

Please briefly describe your child's school performance and experience:
_____

What are your child's hobbies, talents, and strengths?
_____
_____

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD & *CIRCLE* THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety →			Tantrums →			Nausea →		
Depression			Parents Divorced			Stomach Aches		
Mood Changes			Seizures			Fainting		
Anger or Temper			Cries Easily			Dizziness		
Panic			Problems with Friend(s)			Diarrhea		
Fears			Problems in School			Shortness of Breath		
Irritability			Fear of Strangers			Chest Pain		
Concentration			Fighting with Siblings			Lump in the Throat		
Headaches			Issues Re: Divorce			Sweating		
Loss of Memory			Sexually Acting Out			Heart Problems		
Excessive Worry			History of Child Abuse			Muscle Tension		
Wetting the Bed			History of Sexual Abuse			Bruises Easily		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Makes Careless Mistakes		
Separation Anxiety			Hurting Self			Fidgets Frequently		
Alcohol/Drugs			Thoughts of Suicide			Impulsive		
Drinks Caffeine			Sleeping Too Much			Waiting His/Her Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Head Injury			Sleeping Alone			Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems		Physical Abuse		Depression			
Legal Trouble		Sexual Abuse		Anxiety			
Domestic Violence		Hyperactivity		Psychiatric Hospitalization			
Suicide		Learning Disabilities		"Nervous Breakdown"			

Any additional information you would like to include:

_____

_____

_____