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NEW CLIENT INFORMATION

Client Name : _____ Today's Date: _____

Date of Birth: ____ / ____ / ____ Age: _____ Gender: _____ Social Security # _____ - _____ - _____

Marital Status (circle one): single married divorced/separated

Address: _____

City: _____ State: _____ Zip Code: _____

Cell/Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Fax: _____

THE BEST WAY TO REACH ME IS (circle one): Cell/Mobile Home Work Email

IS IT OK TO LEAVE MESSAGES REGARDING APPOINTMENT TIMES, ETC? (circle one): YES NO

IS IT OK TO SEND TEXT MESSAGES TO YOUR CELL/MOBILE? (circle one): YES NO

IS IT OK TO SEND MAIL TO THE ABOVE ADDRESS? (circle one): YES NO

IS IT OK TO SEND EMAIL'S TO THE ABOVE EMAIL? (circle one): YES NO

Please write any specific requests or limitations in communicating with you: _____

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____ Handedness: _____

Current grade in school: _____ School: _____ Teacher: _____

Employed By: _____ Occupation: _____

City: _____ Date Hired: _____

How were you referred to this office? (circle): Self-Referred Doctor Family Friend Ad Internet

Other

Name of internet site/ad/facility/friend/other: _____

Emergency Contact Person: _____ Phone: _____

Name of person who filled out this form: _____

PLEASE DO NOT WRITE BELOW THIS LINE

Payment Due: \$ _____ Diagnosis: _____

CHILD FORM

Please fill out this form for your child as completely as possible. If your child is able to fill in certain information, please allow them to do so. It will help me in my work with them.

PRESENTING PROBLEM:

Please describe the main difficulty that has brought you to seek treatment at this time. Be as specific as you can.

CHILD'S MEDICAL CARE: (From whom or where does your child get medical care?)

Primary Care Doctor _____ Phone: _____ Fax: _____

Date of Last Visit: _____ Address: _____

Medical Problems: _____

Surgeries (for what and when?): _____

Current medications prescribed by this provider: _____

Describe reaction to medications: _____

List any allergies: _____

Other comments: _____

May we contact your primary doctor so that we can coordinate your treatment? (circle one): YES NO

Psychiatrist: _____ Phone: _____ Fax: _____

Date of Last Visit: _____ Address: _____

Psychiatric Problems: _____

Current medications prescribed by this provider: _____

Describe reaction to medications: _____

May we contact your psychiatrist so that we can coordinate your treatment? (circle one): YES NO

Has your child received previous psychological care? (circle one): YES NO

If YES, please indicate which type of treatment (circle): INPATIENT OUTPATIENT BOTH

When: _____ From Whom: _____

For What: _____

When: _____ From Whom: _____

For What: _____

When: _____ From Whom: _____

For What: _____

When: _____ From Whom: _____

For What: _____

May we contact your previous providers(s) for continuity of care? (circle one): YES NO

EDUCATION:

Academic Performance: _____

Behavior's in School: _____

What activities is your child involved in while at school? _____

How does your child interact with peers at school? _____

Has your child ever had to repeat a grade? (circle): YES NO If so, which grade(s)? _____

Has your child ever received special education services? (circle): YES NO If so, which grade(s)? _____

If your child currently has an IEP, please explain: _____

If your child currently as a 504 Plan at school, please explain: _____

Additional Comments about School: _____

PRESENT RELATIONSHIPS:

Parents Marital Status (circle): MARRIED DIVORCED/SEPARATED WIDOWED
SINGLE DATING OTHER _____

If in a relationship, for how long? _____ Quality of Relationship: _____

List all persons living at home other than child:

NAME	AGE	RELATIONSHIP TO CHILD
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Father's Name: _____ Age: _____ Occupation: _____

Describe Father's Relationship with Child: _____

Mother's Name: _____ Age: _____ Occupation: _____

Describe Mother's Relationship with Child: _____

Step-Father's Name: _____ Age: _____ Occupation: _____

Describe Step-Father Relationship with Child: _____

Step-Mother's Name: _____ Age: _____ Occupation: _____

Describe Step-Mother's Relationship with Child: _____

How does your child get along with others in the home? _____

What are your child's favorite activities, sports, hobbies? _____

What are your child's responsibilities at home? _____

Does your child have any behavioral problems? _____

Describe how child is disciplined at home: _____

How does child respond to form(s) of discipline? _____

Any current or pending civil or criminal litigations, lawsuits or divorce/custody disputes? (circle one): YES NO

If YES, please explain: _____

Who has legal custody of this child? _____

PREGNANCY, BIRTH, AND EARLY DEVELOPMENT:

What kind of delivery during birth? (circle): VAGINAL C-SECTION BREECH

Note any complications during delivery: _____

Note any complications during pregnancy: _____

Prescribed medications taken during pregnancy: _____

Substance use during pregnancy (include cigarettes): _____

Note any post-delivery complications: _____

Eating patterns during infancy: _____

Sleeping patterns during infancy: _____

Temperament: _____

How were developmental milestones met? (circle one): EARLY ON-TIME LATE

If late, please provide additional information here: _____

Check any of the following that were present during the first few years of life:

___ Did Not Enjoy Cuddling ___ Frequent Head-Banging ___ Mute

___ Was Not Calmed by Being Held ___ Difficulty Nursing ___ Loss of Speech/Babbling

<input type="checkbox"/> Difficult to Comfort	<input type="checkbox"/> Constantly into Everything	<input type="checkbox"/> Lack of Facial Expression
<input type="checkbox"/> Colic	<input type="checkbox"/> Lack of Eye Contact	<input type="checkbox"/> No Body Gestures
<input type="checkbox"/> Excessive Restlessness	<input type="checkbox"/> Unresponsive	<input type="checkbox"/> Lack of Interest/Enjoyment
<input type="checkbox"/> Excessive Irritability	<input type="checkbox"/> Poor Appetite	
<input type="checkbox"/> Diminished Sleep	<input type="checkbox"/> Delayed Language	

FAMILY MEDICAL HISTORY:

Describe any illness that runs in the family (cancer, epilepsy, thyroid, etc.): _____

FAMILY HISTORY OF PSYCHIATRIC ISSUES: (Check any that apply to your family history):

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Dementia	<input type="checkbox"/> Phobia	<input type="checkbox"/> Other _____
<input type="checkbox"/> Addiction	<input type="checkbox"/> Depression	<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Other _____
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Delusions	<input type="checkbox"/> Psychosis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Dissociation	<input type="checkbox"/> PTSD/Trauma	<input type="checkbox"/> Other _____
<input type="checkbox"/> Anger Management	<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Perfectionism	
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Emotional Eating	<input type="checkbox"/> Schizophrenia	
<input type="checkbox"/> Antisocial	<input type="checkbox"/> History of Neglect	<input type="checkbox"/> Self-Control	
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Homicidal	<input type="checkbox"/> Sexual Abuse	
<input type="checkbox"/> Bereavement	<input type="checkbox"/> Major Mental Illness	<input type="checkbox"/> Self-Harm	
<input type="checkbox"/> Bipolar	<input type="checkbox"/> Over-Exercise	<input type="checkbox"/> Suicide	
<input type="checkbox"/> Bullying	<input type="checkbox"/> Obsessions	<input type="checkbox"/> Treatment (Inpatient)	
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Treatment (Outpatient)	
<input type="checkbox"/> Conduct Problems	<input type="checkbox"/> Personality Disorder		

Past or Present Drug/Alcohol Use and Abuse (treatments, AA/NA): _____

Past or Present History of Abuse or Neglect (physical, emotional, sexual): _____

Suicide Attempt(s) or Violent Behavior (describe: ages, reasons, circumstances, how, etc.): _____

Friendships, Community, Religious or Spiritual Involvement (describe quality, frequency, etc.): _____

Strengths and Accomplishment (Please lists strengths, talents, skills, and accomplishments):

OTHER:

What other information about yourself do you think would be important for us to know?

PRINT Patient Name

Date

SIGNATURE of Patient/Parent or Legal Guardian

Date