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PATIENT INFORMATION

Today's Date: _____ Date of Birth:_____

Client Name:_____ Gender: M F

Street Address:_____

City:_____ State: _____Zip Code:_____

Is patient employed or in school: YES NO If yes where:_____

Telephone / Contact (put a star next to preferred contact number)

Home:_____ Cell:_____

Work:_____ Email: _____

Emergency Contact

Name:_____ Telephone #:_____

Relationship:_____

How were you referred?_____

Primary reason for seeking therapy:

_____

_____

_____

IF PATIENT IS A MINOR:

School:_____Grade:_____

Does your child have a 504 plan or an IEP? (if yes, please circle one): 504 IEP

Pediatrician:_____

Others Living In the Home (Siblings, Grandparents etc):

Name:_____ Age:_____ Relationship:_____

Name:_____ Age:_____ Relationship:_____

Name:_____ Age:_____ Relationship:_____

Name:_____ Age:_____ Relationship:_____

Parents are: MARRIED DIVORCED SEPARATED

Parent 1 Name:_____

Parent 1 Address: _____

_____

Parent 1 Home Phone:_____ Cell Phone:_____

Parent 1 Occupation: _____Work Phone:_____

Parent 2 Name:_____

Parent 2 Address: _____

_____

Parent 2 Home Phone:_____ Cell Phone:_____

Parent 2 Occupation: _____Work Phone:_____

Treatment History

Has the child previously had mental health care: YES NO

If YES, please indicate when/ with whom and any diagnoses:_____

_____

Current Psychiatrist (If any):_____

Please List Current Medications and Dosages:_____

_____

Has child had a Psychoeducational or a Neuropsychological Evaluation: YES NO

Has child had a psychiatric hospitalization: YES NO (if yes, please list where/when)

_____

Is there is history of:

Suicide Attempts: YES NO Suicidal Thoughts: YES NO

Substance Use: YES NO Abuse: YES NO

If YES to any, please explain:_____

_____

Psychosocial History

Any early developmental challenges (birth complications, late milestones, need for speech or occupational therapy services). If so, please explain: _____

_____

_____

Extracurricular activities/Strengths/Interests: _____

_____

_____

Any current or past medical concerns (other than typical childhood illnesses) such as head injuries, hospitalizations, chronic illness: _____

_____

_____

Does your child's teacher(s) describe any of the following as significant classroom problems?
_____ Doesn't sit still in his/her seat.
_____ Shouts out; doesn't wait to be called upon.
_____ Does not cooperate in group activities.
_____ Has difficulty interacting with peers
_____ Frequently Daydreams/ Off-Task
_____ Learning Problems
_____ Other behavioral problems _____

Difficulties with Sleeping/Eating Habits: _____

_____

_____

Any Additional information You Think May Be Helpful: