Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. *Please fill out this form and bring it to your first session.*

Child's Name: Date (mm/dd/yy):

DOB (mm/dd/yy): Age: Gender:

Address: City/State: Zip:

Parent/Guardian Name (s):

Home Phone: May we leave a message? Select Cell/Other Phone: May we leave a message? Select

E-Mail: May we Email you? Select *Please note:* Email correspondence is not considered to be a confidential medium of communication.

Reason for Referral/
Referred by (if any):

School: Phone: Grade: Teacher:

How does your child do in school academically?

How does your child do in school behaviorally?

Does your child have a learning or physical disability? Yes, No, Maybe Select One

Specify:

Does your child have a mental health diagnosis? Yes, No Select One

Specify:

Does your family have specific spiritual beliefs?

Medical History

During pregnancy, did mother use: ☐ Cigarettes ☐ Alcohol ☐ Drugs ☐ Experience Extreme Stress?

Specify frequency, amounts, and duration:

List any birth complications (Ex: Premature, jaundice, C-section, etc.):

List any Medical conditions or history (Ex: Surgeries, broken bones, allergies, etc.):

Does child use: ☐ Cigarettes ☐ Alcohol ☐ Drugs

Specify frequency, amounts, and duration:

Primary Care Physician: Phone: Last seen on:

Psychiatrist: Phone: Last seen on:

Current medications:
(dosage and frequency)

Medication Allergies:

Other Allergies:

In the first two years, did your child experience: ☐ Separation from mother ☐ Out of home care ☐ Disruption in bonding
☐ Depression of mother ☐ Abuse ☐ Neglect ☐ Chronic pain ☐ Chronic Illness ☐ Parental Stress

If yes, please specify:

Developmental and Family History

Reached developmental milestones: ☐ On time ☐ Early ☐ Late | How many times has the child moved homes?

What are five adjectives that describe:

Primary Caregiver:

Coparent:

Child:

Parental Relationship:

Parent 1: DOB:

Parent 2: DOB:

Parents are: ☐ Married | when? ☐ Separated | when? ☐ Divorced | when?

Siblings (1st to last):

Name:	Age:	Name:	Age:
Name:	Age:	Name:	Age:
Name:	Age:	Name:	Age:

People in household, if different from above:

Was your child adopted by either parent?: ☐ Y, ☐ N; If yes, the date you/they became caretaker:

Who is the primary caregiver for this child?

Does Parent 1 work outside of the home? ☐ Y, ☐ N; Occupation:

Hours: Parent 1's highest level of education:

Does Parent 2 work outside of the home? ☐ Y, ☐ N; Occupation:

Hours: Parent 2's highest level of education:

Visitation schedule:
If separated or divorced

Custody arrangement regarding
physical and mental health care:

Does either parent have legal issues?

List any history of mental illness or
addiction in immediate or extended family
(Depression, anxiety, bi-polar disorder, suicide attempts,
alcoholism, drugs, ADHD, schizophrenia, etc.)

Have children witnessed domestic violence? Select Specify:

How is your child disciplined?
Please list each method and
frequency of use:

Trauma History

Has your child been verbally abused?
Select One Specify:

Has your child been physically abused?
Select One Specify:

Has your child been sexually abused?
Select One Specify:

Other stressors or traumas?

Concerns

Mark the symptoms your child/adolescent displays and list the number of times per week it is displayed:

◯ Anger	◯ Anxiety	◯ Bed wetting	◯ Acts out sexually	◯ Conduct problems
◯ Controlling Defecation	◯ Has unusual sexual knowledge	◯ Day wetting	◯ Defiance	◯ Depression/ sadness
◯ Homicidal thoughts	◯ Disassociates actions	◯ Drug or alcohol use	◯ Hyperactivity	◯ Masturbates excessively
◯ Hyper vigilance	◯ Impaired conscience	◯ Isolation	◯ Lack of empathy	◯ Lack of motivation
◯ Lethargy	◯ Low impulse control	◯ Low self-esteem	◯ Lying	◯ Nightmares
◯ Plays out sexual themes	◯ Plays out violent themes	◯ Phobias	◯ Peer problems	◯ Running Away
◯ Obsesses Over/Under eating	◯ Shy	◯ Sleeplessness	◯ Somatic Symptoms: Headaches/Stomachaches, etc.	
◯ Stealing	◯ Suicidal thoughts	◯ Tantrums	◯	

Other:

How does your child/adolescent handle anger?

Has the child/adolescent experienced any significant loss? If yes, explain:

What do you view as your child/ adolescent's major strengths and positive traits?

What are your child/ adolescent's hobbies?

What are your child/adolescent's responsibilities at home?

How well does your child/ adolescent's handle these responsibilities?

Briefly describe your goals for your child/adolescent's therapy:

Please list any other information you deem to be important for the therapist to know:

Contact in case of emergency?

Name: Phone: Relationship: