

Please provide the following information for my records. Leave blank any question you would prefer not to answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session or allow yourself 30 minutes prior to your appointment to complete the form in the office.

Client's name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian: _____
(Last) (First) (Middle Initial)

(Last) (First) (Middle Initial)

Birth Date: ____ / ____ / ____ Age: ____ Gender: Male Female

Home Address: _____
(Street and Number)

(City) (State) (Zip)

Home Phone: (____) _____ - May I leave a message? Yes No

Cell/Other Phone: (____) _____ - May I leave a message? Yes No

Cell/Other Phone: (____) _____ - May I leave a message? Yes No

E-mail: _____ May I email you? Yes No

* Please be aware that email is not confidential. I will use it only for scheduling purposes.

How did you find out about my services?:

Is your child receiving psychiatric services (medication), professional counseling or therapy elsewhere?

Yes No If yes, current provider's name: _____

Has your child been in therapy before?

Yes No If yes, previous therapist's name: _____

Is your child currently taking prescribed psychiatric medication (antidepressants or others)?

Yes No If yes, please list:

Has your child previously been prescribed psychiatric medication?

Yes No If yes, please list:

What are you seeking help for today regarding your child?

How are the above issues affecting your child's ability to function effectively?

What are your goals for therapy for your child?

What are effective coping strategies are you/your child using now?

What do you consider to be your child's strengths/What do you like most about your child?

Any additional information that would help me in understanding your concerns or problems:

CURRENT ISSUES

Please indicate which of the following issues/problems *you would like to address in therapy*:

- | | |
|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Body image problems |
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Lack of friends | <input type="checkbox"/> Traumatic events |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Victim of abuse (physical or sexual) |
| <input type="checkbox"/> Suicide thoughts/attempt | <input type="checkbox"/> Grief/loss |
| <input type="checkbox"/> Homicidal thoughts | <input type="checkbox"/> Problems at work/school |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Family conflict |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Alcohol/substance abuse |
| <input type="checkbox"/> Anxiety/panic attacks | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Phobias | _____ |

In the PAST has your child ever experienced:

- | | |
|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Body image problems |
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Lack of friends | <input type="checkbox"/> Traumatic events |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Victim of abuse (physical or sexual) |
| <input type="checkbox"/> Suicide thoughts/attempt | <input type="checkbox"/> Grief/loss |
| <input type="checkbox"/> Homicidal thoughts | <input type="checkbox"/> Problems at work/school |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Family conflict |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Anxiety/panic attacks | _____ |
| <input type="checkbox"/> Phobias | _____ |
| <input type="checkbox"/> Alcohol/substance abuse | |

PERSONAL AND FAMILY HISTORY

| <u>Relationship</u> | <u>Name</u> | <u>Age</u> | <u>Living</u> | | <u>Living with you</u> | |
|---------------------|-------------|------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | | | <u>Yes</u> | <u>No</u> | <u>Yes</u> | <u>No</u> |
| Mother | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Father | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Spouse | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Children | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other significant people in your child's life (e.g., girlfriends/boyfriends, brothers, sisters, grandparents, step-relatives, half-relatives)

| <u>Relationship</u> | <u>Name</u> | <u>Age</u> | <u>Living</u> | | <u>Living with you</u> | |
|---------------------|-------------|------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | | | <u>Yes</u> | <u>No</u> | <u>Yes</u> | <u>No</u> |
| _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Parental Information:

- Parents legally married Parents have ever been separated Parents ever divorced
 Father remarried Mother remarried

Assessment of current parental relationship (if applicable): Good Fair Poor

Special circumstances (e.g., being raised by person other than parents, information about spouse/children not living with the child, etc.): _____

Family Mental Health History:

Has anyone in your child’s family (either immediate family members or relatives) experienced difficulties with the following?:

- | | | |
|--|--|--------------|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Suicide Attempts | Other: _____ |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Trauma History | _____ |
| <input type="checkbox"/> Anxiety Disorders | <input type="checkbox"/> Eating Disorders | _____ |
| <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Learning Disabilities | _____ |
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Alcohol/Substance Abuse | _____ |

Childhood:

Were there any special, unusual, or traumatic circumstances that have affected your child?

- Yes No

If yes, please describe: _____

Has your child ever experienced child abuse? Yes No

If yes, which type(s)? Sexual Physical Verbal

If yes, was your child the: Victim Perpetrator Witness

Other childhood issues: Neglect Inadequate nutrition

Other (please specify): _____

Other significant information: _____

SOCIAL RELATIONSHIPS

Check how your child generally gets along with other people: (check all that apply)

- Affectionate Aggressive Avoidant Fight/argue often Follower
 Friendly Leader Outgoing Shy/withdrawn Submissive
 Other (specify): _____

Comments: _____

OCCUPATIONAL/SCHOOL INFORMATION:

Is your child currently a student?

- Yes No If yes, school's name and current year/grade:

Is your child currently employed?

- Yes No If yes, who is your child's current employer/position?

Please list any school/work related stressors, if any: _____

HEALTH INFORMATION

How is your child's physical health at present?

- Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

Is your child having any problems with sleep? Yes No

If yes, check where applicable:

- Sleeping too little Sleeping too much Poor quality sleep
 Disturbing dreams Other _____

How many times per week does your child exercise? _____

Approximately how long each time? _____

Is your child having any difficulty with appetite or eating habits? Yes No

If yes: Eating less Eating more Binging Restricting

Has your child experienced significant weight change in the last 2 months? Yes No

Does your child regularly use alcohol? Yes No.

If yes, how often? _____

How often does your child engage in recreational drug use? Yes No.

If yes, how often? _____

Has your child had suicidal thoughts recently?

Frequently Sometimes Rarely Never

Has your child had them in the past?

Frequently Sometimes Rarely Never

In the last year, has your child experienced any significant life changes or stressors?

Additional Information:

