NEW PATIENT INFORMATION - MINOR

Date:_____
Name of Child/Adolescent: _____ Age:_____ Gender:_____
Date of Birth:_____ School:_____ Grade:_____
Name of person filling out form: _____ Relationship to child:_____

Please take some time to fill out the information below before your first appointment. It will help me better understand the issues that are bringing you to therapy and how I can help. Thank you!

Please describe the problems that you would like help with:_____
_____
_____
_____

When did these issues begin?_____
_____

Please check to indicate if your child/teen has experienced any of the problems below either currently (in the last 6 months) or in the past.

Now	Past		Now	Past	
____	____	Depression/sadness	____	____	Anxiety/nervousness
____	____	Thoughts of suicide	____	____	Thoughts of harming others
____	____	Recurrent/intrusive thoughts	____	____	Nightmares
____	____	Difficulty sleeping	____	____	Loss of appetite
____	____	Overeating	____	____	Weight loss
____	____	Weight gain	____	____	Sexually inappropriate behavior
____	____	See or hear things others do not	____	____	Apathy
____	____	Restricting calorie intake	____	____	Overeating and vomiting
____	____	Explosive anger	____	____	Rapid mood changes
____	____	Euphoria (feeling on top of the world)	____	____	Decreased need for sleep
____	____	Racing thoughts	____	____	Distractible
____	____	Difficulty organizing/planning time	____	____	Feeling worthless
____	____	Fatigue	____	____	Loss of interest in activities
____	____	Low self esteem	____	____	Feelings of helplessness
____	____	Feelings of hopelessness	____	____	Fears or phobias
____	____	Panic or anxiety attacks	____	____	Impulsive behavior
____	____	Overwhelming need to perform certain behaviors/rituals	____	____	Recurrent/intrusive disturbing recollections of past events
____	____	Significant concern with health	____	____	Thoughts of harming self
____	____	Poor frustration tolerance	____	____	Aggressive behavior
____	____	Unmotivated	____	____	Trouble separating from parent
____	____	Quiet	____	____	Resists change
____	____	Wets bed or clothes	____	____	Bowel movements in clothes
____	____	Difficulty sitting still	____	____	Difficulty following instruction
____	____	Destroys property	____	____	Cruel to animals
____	____	Frequent stomach aches	____	____	Shy and withdrawn
____	____	Sensitive to touch, light, sound,..	____	____	Stealing
____	____	Frequent lying	____	____	Refuses to go to school
____	____	Difficulty reading social cues	____	____	Odd emotional reactions
____	____	Other:_____	____	____	Other:_____

Additional comments you would like to make about any of the symptoms checked above:_____
_____
_____
_____

Please indicate which, if any, of the stressors below your child is currently experiencing (in the last 6 months) or has experienced in the past.

Now	Past		Now	Past	
____	____	Death of family member	____	____	Parents separated
____	____	Illness of family member	____	____	Illness of friend
____	____	Death of friend	____	____	Personal injury/illness
____	____	Parents divorce	____	____	Academic difficulties
____	____	Conflict within family	____	____	Conflict with friends
____	____	Change in residence	____	____	Verbal/emotional abuse
____	____	Incest or sexual abuse	____	____	Physical abuse
____	____	Stress in household	____	____	Other: _____

Additional comments you would like to make about any of the stressors checked above:_____
_____
_____
_____

Has she/he received therapy in the past? If so, with whom, for how long, and what were the issues that brought her/him to therapy?_____
_____
_____

What did you like or dislike about that therapy?_____
_____

If applicable, circle the substances your child currently uses (even if only occasionally or in small amounts):

Alcohol Tobacco Marijuana Barbiturates Tranquilizers Amphetamines
Crack Cocaine Opiates Hallucinogenics PCP Ecstasy Spice

Circle the substances your child has used in the past:

Alcohol Tobacco Marijuana Barbiturates Tranquilizers Amphetamines
Crack Cocaine Opiates Hallucinogenics PCP Ecstasy Spice

Has your child ever been hospitalized for psychological problems or substance abuse? If so, where and when?
_____
_____

Has he/she ever had a psychological evaluation? _____
List any past or current medical/physical problems:_____
_____
_____

List any medications your child is currently taking, both medical and psychiatric:_____
_____
_____

Birth and Developmental History

Place of Birth:_____
Were parents married or living together at the time of birth?_____
Was mother under a doctor's care during pregnancy?_____
Was the child adopted?_____ If so, at what age?_____
Medications taken during pregnancy?_____
Were drugs or alcohol used during pregnancy? If so, please specify._____
Was there significant emotional stress during pregnancy? If so, please specify._____

Circle any illness mother suffered from during pregnancy:

Anemia Toxemia Herpes Measles German Measles Bleeding
Kidney disease Heart disease Hypertension Abdominal trauma Infection Diabetes

Was the birth: On time_____ Premature___(By how long_____) Late____ (By how long_____)
Was labor: Spontaneous____ Induced____ Duration of labor _____ Cesarean?____
Was the presentation: Normal____ Breach____ Transverse____ Posterior first_____

Did the baby experience any of these problems:

Fetal distress____ Prolapsed cord____ Low placenta (placenta previa)____
Premature separation of the placenta (Abruptio placenta) ____
Cord wrapped around the neck ____

Other problems the child or mother had?_____
Was general anesthesia used?_____ Were forceps used?_____ Any breathing problems?_____
APGAR score:_____ Birthweight:_____ Length:_____

Circle those that apply for the first few weeks after birth:

Excessive sleeping Laziness Irritability Excessive crying Stiffness Limpness
Tremors Twitching Feeding difficulties Vomitting Jaundice

Any medical treatment the baby received after birth:_____

Approximate ages that developmental milestones were achieved:

Head control_____ Rolled over_____ Sat alone_____ Walked_____ Run_____
Said first word_____ Used sentences_____ Fed self with utensils_____ Toilet trained_____
Dress self_____ Tie shoes_____ Color within lines_____

Circle any problems that occurred later in development:

Hearing Speaking Stuttering Reading Writing Spelling
Behavior Arithmetic Hyperactivity Seizures Coordination Attentional difficulties

Family History

Fathers name_____ Age_____
Education_____Occupation_____
Mothers name_____ Age_____
Education_____Occupation_____
Parents married?_____ Number of years married_____
Living together but not married?_____ Number of years together?_____
Current marital problems?_____
If separated when?_____ If divorced, when?_____
What are custody arrangements?_____
_____
Subsequent marriages? For Father?_____ For Mother?_____

Please provide information regarding step-parents if applicable:

Name	Age	Education	Occupation	# years (in child's life)
_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____

Names and ages of brothers and sisters, including step-siblings:_____
_____

List family members with any of the following problems:
Alcohol/drug abuse_____
Emotional/behavioral problems_____
Criminal history_____
Developmental delay_____
Medical problems_____
Learning disabilities_____

Social History

How many friends does your child have in neighborhood and school?_____
How often do they play together?_____
Are there particular issues or conflicts your child has with friends or peers?_____
_____
What does your child most frequently like to play?_____
How is your child perceived by peers?_____
What activities or sports is your child involved in?_____
Does your child attend church?_____

What activities do you typically participate in with your child?_____
What are common things your child will get in trouble for?_____
What are your frustrations with parenting your child?_____
How do you discipline your child when they misbehave?_____

If applicable, does he/she have a girl/boyfriend?_____ How long involved?_____
Any problems in this relationship?_____
Any past significant relationships?_____
Is he/she sexually active?_____ If so, starting when?_____ Birth control?_____

Educational History

Current grade:_____ Current school:_____
Hardest subject:_____ Favorite subject:_____
Typical grades earned in elementary school:_____
Junior High G.P.A.:_____ High School G.P.A.:_____
Any grades repeated? If so, which one._____
Learning Problems:_____
Special Education placement? IEP or 504?_____
Expulsions/suspensions/conduct problems:_____
Extracurricular activities at school:_____

Any other information that you want me to know before our appointment?_____
_____
_____
Please describe your goals for therapy:_____
_____
_____
_____
Any questions you want addressed during our first session?_____
_____
_____

Thank you for taking the time to complete this paperwork. I look forward to working with you and your family to help you achieve your goals!