Patient: _____

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PATIENT INFORMATION
(Please use the back and additional sheets of paper as necessary.)

Name:

Social Security Number:

Age: _____

Birthdate: _____

Lives with:

If parents are divorced, how old was patient when they divorced?

Emotions surrounding divorce:

Custody arrangement:

Feelings towards step-parents:

Patient: _____

School:

Grade: _____

Academic Difficulties:

Physical/Health Problems:

Social Issues:

Family Conflict:

Parenting Style:

Mental Health Issues (anxiety/depression/etc.):

Patient: _____

Mother's Background

Name:

Occupation:

Academic Difficulties:

Physical/Health Problems:

Mental Health Issues:

Father's Background

Name:

Occupation:

Academic Difficulties:

Physical/Health Problems:

Mental Health Issues:

Patient: _____

Step-Mother's Background

Name:

Occupation:

Academic Difficulties:

Physical/Health Problems:

Mental Health Issues:

Step-Father's Background

Name:

Occupation:

Academic Difficulties:

Physical/Health Problems:

Mental Health Issues:

Patient: _____

Siblings:

Name:

Age:

Academic Difficulties:

Physical/Health Problems:

Mental Health Issues:

Name:

Age:

Academic Difficulties:

Physical/Health Problems:

Mental Health Issues:

Patient: _____

Family History

Please *describe* if any of the following events have occurred in your family or to your child?

___ Loss of job by parent

___ Mother beginning to work

___ Discovery of being adopted

___ Death of parent

___ Child changes schools

___ Birth of brother or sister

___ Marital separation/divorce

___ Child is victim of violence

___ Witnessed violence

___ Family member in serious trouble with the law

___ Child/parent acquires a visible deformity or diagnosed with severe illness

___ Death of close family member/friend other than parent

___ Addition of new adult to family

Patient: _____

___Eating Disorder

___Drug Addiction

___Alcoholism

___ Natural Disaster

___ Physical Abuse

___ Sexual Abuse

___ Emotional Abuse

___ Physical Neglect

___ Emotional Neglect

___ Other Trauma

Prenatal Development

Did patient's mother:
Take any medication during pregnancy? _____ If yes, please describe. _____

Smoke during pregnancy? _____ If yes, please describe.

Drink alcohol during pregnancy? _____ If yes, please

describe. _____

Patient: _____

Use illicit drugs during pregnancy? _____ If yes, please describe. _____

Have prenatal care? _____ If yes, please describe.

Feel emotionally unprepared/unwanted pregnancy? _____ If yes, please describe.

Birth History

Were there any problems during pregnancy? _____ If yes, please describe. _____

Were there any problems during labor or delivery? _____ If yes, please describe. _____

Were there any birth defects or complications after delivery?
If yes, please describe.

Patient: _____

Infant Development

Were there any setbacks/problems in the following areas:

Physical Development (abnormalities in growth):

Motor Development (sitting, crawling, standing, walking, toilet training): _____

Cognitive Development (communication: speaking, reasoning, comprehension): _____

Emotional Development (expression, understanding):

Social Development (parental attachment, peer/stranger interaction):

Patient: _____

Child Development
Were there any setbacks/problems in the following areas:

Physical Development (abnormalities in growth):

Motor Development (fine motor and gross motor skills):

Cognitive Development (communication: speaking, reasoning, comprehension): _____

Emotional Development (anger problems, sensitivity, moody, anxiety, depression, low self-esteem):

Social Development (parental attachment, peer/stranger interaction):

Patient: _____

Medical History
Does the patient have/has had:

Allergies?

Asthma?

Earaches or Infection?

Vomiting Spells?

Prolonged Fever?

Head Injury?

Seizures or Convulsions?

Operations or Surgeries?

Extended Hospitalizations?

Sustained Medications?

Patient: _____

Medical History (continued)

Physical Handicaps?

Wetting/Soiling Pants (after toilet training)?

Other?

Eating/Sleep History
Describe if any of the following problems are occurring:

Nightmares?

Trouble falling asleep?

Trouble waking up?

Constantly tired?

Wetting/Soiling Pants (after toilet training)?

Eats too much?

Poor appetite?

Grinds teeth?

Unhealthy eating?

Patient: _____

Presenting Issue(s):
Briefly describe your reason(s) for seeking help:

How severe are the symptoms? Mild Moderate Severe

How long has this occurred?

Where (home, school, community, etc.) does this occur?

When (certain times of day, with specific people) does this occur?

How have you attempted to resolve these concerns?

Has this been treated by other mental health professionals?

Is so, when and for how long?

How was your experience (good and bad) and Why?

Patient: _____

Is the patient taking any medications for this concern? Yes No

If so, list medications and when taken.

What are current goals for counseling?

Has anyone in your family history ever been suicidal? _____

Has your child been suicidal in the past?_____

Is your child currently suicidal?_____

WHO REFERRED YOU_____ THEIR NUMBER _____