

Please describe why you are seeking treatment?

When did the problem start?

How would you rate the severity of the problem right now?
Mild 0 1 2 3 4 5 6 7 8 9 10 Severe

Problem Checklist

Please indicate which of the problems below are bothering the child at this time:

0= none 1=mild 2=moderate 3=serious 4=severe

- | | |
|--|--|
| 0 1 2 3 4 Suicidal Thoughts/behaviors | 0 1 2 3 4 Hears Voices |
| 0 1 2 3 4 Self Harm | 0 1 2 3 4 Sees things not there |
| 0 1 2 3 4 Feels Hopeless | 0 1 2 3 4 Fits of rage |
| 0 1 2 3 4 Feels Worthless | 0 1 2 3 4 Overly suspicious |
| 0 1 2 3 4 Irritable | 0 1 2 3 4 Few friends |
| 0 1 2 3 4 Sad/Tearful | 0 1 2 3 4 Excessively shy |
| 0 1 2 3 4 Moody | 0 1 2 3 4 Bossy |
| 0 1 2 3 4 Bully | 0 1 2 3 4 Overly sensitive |
| 0 1 2 3 4 Poor sleep | 0 1 2 3 4 Teases others |
| 0 1 2 3 4 Too much sleep | 0 1 2 3 4 Teased by others |
| 0 1 2 3 4 Night Mares | 0 1 2 3 4 Cruel to others/animals |
| 0 1 2 3 4 Poor concentration | 0 1 2 3 4 Lying |
| 0 1 2 3 4 Excessive worry/fears | 0 1 2 3 4 Stealing |
| 0 1 2 3 4 Panic | 0 1 2 3 4 Fire setting |
| 0 1 2 3 4 Irregular eating habits | 0 1 2 3 4 Runs away |
| 0 1 2 3 4 Weight preoccupation | 0 1 2 3 4 Aggression |
| 0 1 2 3 4 Nail biting | 0 1 2 3 4 Truancy |
| 0 1 2 3 4 Repetitive behaviors | 0 1 2 3 4 Sexual acting out |
| 0 1 2 3 4 Thumb sucking | 0 1 2 3 4 Legal problems |
| 0 1 2 3 4 Soiling in pants | 0 1 2 3 4 Authority conflicts |
| 0 1 2 3 4 Bed wetting | 0 1 2 3 4 Tics |
| 0 1 2 3 4 Attention seeking | 0 1 2 3 4 Accident prone |
| 0 1 2 3 4 Stuttering | 0 1 2 3 4 Excessive physical complaints |

Medical History

Please describe all serious illnesses, accidents and surgeries:

illness, accident, surgery	age	hospital stay?	How long?

Any Medical concerns?

Seizures	Yes	No
Eye Problems	Yes	No
Hearing Problems	Yes	No
Blackout spells	Yes	No
Other	Yes	No

Prior psychiatric/psychological treatment, hospitalization or medication? _____ Yes _____ No

If YES, where and when _____

Current medications/ doses _____

List all drug allergies/adverse reactions _____

Drug and Alcohol History

Past or present history of drug or alcohol abuse: Yes No

If YES, please describe _____

Has your child experimented with alcohol or drugs? Yes No

Has your child had any police/legal involvement? _____ Yes _____ No

If yes, please describe.

School History

Name of School:

Teacher:

Counselor:

Grade:

Please circle Yes or No to all responses regarding your child's school experiences:

Learning disabilities	Yes	No
Academic Achievement problems	Yes	No
School avoidance/phobia	Yes	No
Truancy	Yes	No
Behavior problems	Yes	No
Peer problems	Yes	No
IEP	Yes	No
504 plan	Yes	No

Has your child been achieving about as well as you feel he or she should?

Yes No

What best describes the grades he or she usually gets?

_____	Well above average
_____	Somewhat above average
_____	Average
_____	Somewhat below average
_____	Well below average

About how much time does your child spend on homework nightly?

Does your child participate in extracurricular activities?

Has your child ever been evaluated for ADHD or other learning problems? If so, When, where and by whom?

Family History

Who had been the primary caregiver of the child?

Any significant separations during the first three years?

How does your child gets along with others? mark the scale from 1-10
1 being “gets along very poorly “ and 10 being “gets along very well”

Mother: 1 2 3 4 5 6 7 8 9 10

Details _____

Father: 1 2 3 4 5 6 7 8 9 10

Details _____

Stepmother: 1 2 3 4 5 6 7 8 9 10

Details _____

Stepfather: 1 2 3 4 5 6 7 8 9 10

Details _____

Siblings: 1 2 3 4 5 6 7 8 9 10

Details _____

Other family 1 2 3 4 5 6 7 8 9 10

Details _____

Is there any family history of mental illness, developmental disabilities, alcohol/drug abuse, psychiatric treatments or hospitalizations? If so please specify and describe. _____

Has violence been a part of the marriage or any other important relationship in the child's life? If yes, describe

Is there currently any physical violence or verbal abuse in your home?

_____ **Yes** _____ **No**

If yes, describe

Has your child been the victim of sexual, physical, emotional or verbal abuse?

_____ **Yes** _____ **No**

Significant Events in the Child's Life

1.	Death of a parent	Yes	No
2.	Parents' divorce	Yes	No
3.	Parents' separation	Yes	No
4.	Death of a close family member	Yes	No
5.	Major personal injury or illness	Yes	No
6.	Illness of a family member	Yes	No
7.	Change of schools	Yes	No
8.	Pregnancy	Yes	No
9.	Sexual problems	Yes	No
10.	Death of a close friend	Yes	No
11.	Serious relationship problems	Yes	No
12.	Sibling leaving home	Yes	No
13.	Frequent change of residence	Yes	No

Please give the # of any YES items and explain

What would you like to get from your child's/family's treatment here?

Parent/Guardian signature

Date

thank you



INSURANCE INFORMATION

Please complete the following regarding your insurance carrier.

We would also like a copy of your insurance card.

Primary insurance type: _____

Insurance phone number: _____

Claims address: _____

Subscriber name: _____

Sex: (circle one) Male or Female Date of Birth: _____

Subscriber ID: _____

Group #: _____

Subscriber's employer: _____

Deductible: \$ _____ Copayment: \$ _____

Relationship to subscriber: (circle one)

Self

Spouse

Child

Other