

Child/Adolescent Information Form

Today's date: _____

Identification

Child's name: _____ Date of Birth: _____ Age: _____

Father's name: _____ Date of Birth: _____ Age: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ email: _____

Please indicate any restrictions on calls or emails: _____

Mother's name: _____ Date of Birth: _____ Age: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ email: _____

Please indicate any restrictions on calls or emails: _____

Emergency Contact Information

Name: _____ Phone: _____

Address: _____

Relationship to you: _____

Chief Concern

Please describe the main difficulty that has brought you to see me:

Treatment Goals

Please describe what you hope to gain from psychotherapy:

Medical Care (From whom or where do you get your medical care?)

Clinic name: _____ Phone: _____

Doctor's name: _____

Significant Medical Conditions: _____

If you enter treatment with me for psychological problems, may I tell your child's medical doctor so that he or she can be fully informed and we can coordinate your child's treatment? Yes No

Current employer

Employer: _____ Occupation: _____

Family History

If your child has siblings, please list their names, ages, and places of residence: _____

Family history of mental illness or addictions: _____

Past Psychological/Psychiatric Treatment

Has your child ever received psychological, psychiatric, drug or alcohol treatment, or counseling services? Please include both inpatient and outpatient treatment.

No Yes

If yes, please indicate:

When	From Whom	For What	Results

Has your child ever taken medications for psychiatric or emotional problems? No Yes

If yes, please indicate:

When	From Whom	Medication	For What	Results

Alcohol Use

Does your child use alcohol? _____ If yes, how much and how frequently does he/she drink?

Amount: _____

Frequency: _____

Recreational Drug Use

Does your child recreationally use prescription or illegal drugs? _____ If yes, what type and how much does he/she use?

Type: _____ Amount: _____

Frequency: _____

Current Problems and Symptoms

Please indicate the degree to which the following items are a problem for your child in the past two weeks by placing the appropriate number next to the problem.

1 – No Difficulty

2 – Mild Difficulty

3 – Great Difficulty

4 – Overwhelmed

_____ Job _____ School _____ Alcohol _____ Partner/Relationship

_____ Financial _____ Family _____ Drug Use _____ Sexual Activity

Rate each problem 0-4 (0 = no problem and 4 = major problem) and CIRCLE all words in parenthesis that pertain to your child.

_____ Anxiety (Worry, fear, scared feelings, excessive guilt)

_____ Depression (unhappiness, hopelessness, lack of motivation, loss of enjoyment, poor concentration)

_____ Thinking (poor concentration, procrastination, poor memory, intrusive thoughts, obsessive thoughts)

_____ Physical Symptoms (pain, headaches, fatigue, stomach aches)

_____ Self Control (uncontrolled anger, overpowering sexual desires, compulsive/addictive behavior)

_____ Emotions (change quickly, hard to control, control too much)

_____ Relationships with others (friend, co-worker, partner)

_____ Sleep (difficulty falling asleep, difficulty staying asleep, sleeping too little/much)

_____ Appetite/Eating (lack of appetite, recent weight gain, recent weight loss)

Salmaan Toor, PhD
Licensed Clinical Psychologist

Our Psychotherapy Agreement

Informed consent to treatment: I, the patient (or his or her parent or guardian), understand that I have the right to not sign this form. My signature below indicates that I have read, discussed, and received a copy of the Notice of Privacy and Psychotherapy Information forms. My signature does not indicate that I am waiving any of my rights. I also understand that any of the points in the Notice of Privacy and Psychotherapy Information forms can be discussed and may be changed by mutual agreement at any time. I understand my rights to privacy and any exceptions to my rights to privacy, and that there are risks associated with treatment. I have read, or had read to me the Notice of Privacy and Psychotherapy Information forms. I have discussed those points I did not understand, and have had questions, if any, fully answered. I agree to the points in this document and enter into therapy with this therapist as shown by my signature here.

Signature of patient (or person acting for patient)

Date

Printed name

Relationship to client: Self Parent Legal guardian

Consent to Use and Disclose Your Health Information

When I examine, test, diagnose, treat, or refer you, I will be collecting what the law calls “protected health information” (PHI) about you. I need to use this information in my office to decide on what treatment is best for you and to provide actual treatment to you. I may also share this information with others to arrange payment for your treatment, to help carry out certain business functions, or to help provide other treatment to you.

By signing this form, you are also agreeing to let me use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have received the notice of privacy practices, which explains in more details what your rights are and how I can use and share your information. After you have signed this consent, you have the right to revoke it by providing me a request in writing.

Signature of patient (or person acting for patient)

Date

Printed name

Relationship to patient: Self Parent Legal guardian