Norwood Psychological Group

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Client Information Form

This Form is Confidential

Your Child's Name: _____
LAST FIRST MI

Parent or Legal Guardian's Name: _____
LAST FIRST MI

Child's Date of Birth: _____ Today's Date: _____ Gender: _____

Parent or Legal Guardian's Social Security #: _____

Home Street Address: _____

City: _____ State: _____ Zip: _____

Parent or Legal Guardian's Name of Employer: _____

Address of Employer: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Referred by: _____

May I have your permission to thank this person for the referral? YES NO

If referred by another clinician, would you like for us to communicate with one another? YES NO

Person(s) to notify in case of any emergency: _____
NAME PHONE

We will only contact this person if we believe it is a life or death emergency. Please provide your signature to indicate that we may do so: _____
Your Signature

Please briefly describe your child's presenting concerns:

_____

_____

_____

_____

_____

What are your/your child's goals for therapy?

_____

_____

_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses your child has had:

_____

_____

_____

Current Medications (if you need more room, please write on the back of this page):

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous medical hospitalizations (Approximate dates and reasons):

_____

_____

Previous psychiatric hospitalizations (Approximate dates and reason):

_____

_____

Has your child ever talked with a psychiatrist, psychologist, or other mental health professional? (if yes, please list approximate dates and reasons):

_____

_____

_____

Sexual & Gender Identity: ___ Heterosexual ___ Lesbian ___Gay ___Bisexual ___Transgender
___ Asexual ___ In Question ___ Other: _____

Racial/Ethnic Identify:

___ African/African-American/Black
___American Indian/Alaska Native
___ Asian/Asian-American/Asian Pacific Islander
___ Bi-Racial/Multi-Racial
___ Latino/Latino-American
___ Middle Eastern/Middle Eastern-American
___ White/ European-American
___ Other: _____

FAMILY:

How would you describe your child's relationship with his or her mother?

_____

_____

How would you describe your child's relationship with his or her father?

_____

_____

Are the child's parents still married or did they divorce? _____

If they divorced, how old was the child when the parents separated or divorced and how do you think this impacted him or her? _____

_____

Please list all individuals that live in the home, their age and their relationship with the child		
Name	Age	(Relationship (e.g., mother, father, stepmother, stepfather, sister, brother, aunt, grandparent, step-sibling, friend)

If any brothers or sisters are living outside the home, please list their names and ages.	
Name	Age

Please describe your child's relationship with his or her grandparents:

_____

_____

_____

How would you describe your child's relationship with their siblings?

_____

Were there any other primary care givers who have had a significant relationship with your child? If so, please describe how these people may have impacted your child's life:

SOCIAL SUPPORT, SELF_CARE, & EDUCATION

Child's current level of satisfaction with friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

How would you describe your child's relationship with his/her peers?

Please briefly describe any history of abuse, neglect and/or trauma:

Briefly describe your child's self-care and coping skills:

What are your child's diet, weight, and exercise/activity patterns?

Please briefly describe your child's school performance and experience:

What are your child's hobbies, talents, and strengths?

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD & **CIRCLE** THE MAIN PROBLEM:

	Difficulty with:	**NOW**	**PAST**		**Difficulty with:**	**NOW**	**PAST**		**Difficulty with:**	**NOW**	**PAST**	
	Anxiety				Tantrums				Nausea			
	Depression				Parents Divorced				Stomach Aches			
	Mood Changes				Siezures				Fainting			
	Anger or Temper				Cries Easily				Dizziness			
	Panic				Problems with Friend(s)				Diarrhea			
	Fears				Problems in School				Shortness of Breath			
	Irritability				Fear of Strangers				Chest Pain			
	Concentration				Fighting with Siblings				Lump in the Throat			
	Headaches				Issues RE: Divorce				Sweating			
	Loss of Memory				Sexually Acting Out				Heart Problems			
	Excessive Worry				History of Child Abuse				Muscle Tension			
	Wetting the Bed				Hitory of Sexual Abuse				Bruises Easily			
	Trusting Others				Domestic Violence				Allergies			
	Communicating with others				Thoughts of hurting someone else				Often Make Careless Mistakes			
	Separation Anxiety				Hurting Self				Fidget Frequently			
	Alcohol/Drugs				Thoughts of Suicide				Impulsive			
	Drinks Caffeine				Sleeping too Much				Waiting His/Her Turn			
	Frequent Vomiting				Sleeping too Little				Completing Tasks			
	Eating Problems				Getting to Sleep				Paying Attention			
	Severe Weight Gain				Waking too Early				Easily Distracted by Noise			
	Severe Weight Loss				Nightmares				Hyperactivity			
	Head Injury				Sleeping Alone				Chills or Hot Flashes			

FAMILY HISTORY OF (Check all that apply):

	Drug/Alcohol Problems			Physical Abuse			Depression		
	Legal Trouble			Sexual Abuse			Anxiety		
	Domestic Violence			Hyperactivity			Psychiatric Hospitalization		
	Suicide			Learning Disabilities			“Nervous Breakdown”		

Any additional information you would like to include:

_____

_____

_____

_____