Northwest Psychological Center, P.C.

Please fill out the entire form, answering the questions as they pertain to your child or teen. Leave blank any that are unclear or that you want additional clarification on. Thank you.

General Information:

Child's name: ____________________________Nickname: ________________Date of Birth: _____/_____/_____

Sex: Male _____ Female ______ SSN: _______________________ Today's date: _____/_____/_____

Parent's Name #1: ________________________Home phone: (____) _____________ Cell: (____) _____________

Address:_____________________________________ City: ________________ State: ______ Zip: ____________

Employer: __________________________Work phone: (_____) ____________ Email: _____________________

Parent's Name #2: ________________________ Home home: (____) _____________ Cell: (____) ____________

Address: _____________________________________ City: _______________ State: ______ Zip: ____________

Employer: __________________________ Work phone: (____) ____________ Email: ______________________

Who will be responsible for making/keeping appointments?____

Ok to leave phone message? Yes No Which number? ___________________ Ok to send mail? Yes No

Emergency contact/Relation: _______________________ Phone: (____) __________ Alt phone:(____)__________

Child's primary care provider: _________________________Clinic name/phone:___________________________

Allergies: ______________________________ Medical conditions: ______________________________________

Grade level and school: ______________________________Interests/hobbies: ___________________________

I was referred by: ____

Insurance Information:

Insurance Provider: _____________________________Subscriber's name: _______________________________

Subscriber's birthdate: _____/_____/_____ Subscriber's address (if different than above): __________________

Name of employer: _________________

Insurance phone: (____) __________ Address: ____

ID#: __________________________ Group #: _________________________

**A copy of your card will be made if you would like your insurance to be billed for reimbursement.

Therapy Goals and History:

What brings you and your child in?____

____

What would you like to be different? ____

____

Who supports you and your family in your decision to begin counseling?__________________

____

Has your child seen a therapist before?   Yes   No

When? ________________________________From 1-10, rate previous experiences: ________

Name(s) of previous therapist(s): ___________________________ Phone: (____) __________

What helped? _________________________ ______________________________

What didn't? ____

Family History:

Who lives in the home? Names, ages and relationship.______________________________

____

____

Who are the significant adult figures in your child's life?_____________________________

Describe significant changes/transitions in your child's life and the age that they occurred. For example, divorce, moves, change in schools, death/loss, removal from parents' care.___________________________

____

____

____

If parents are divorced or separated, what are the current custody and visitation arrangements?___________

____

Symptom Checklist:

Check 0, if you are not currently concerned about the symptom; 1, if it is a mild concern; 2, if it is a moderate concern and 3, if it is a serious concern.

Symptom	0	1	2	3	Symptom	0	1	2	3
Depressed mood/sadness					Sleep Trouble				
Grief and loss					Fatigue/low energy				
Loss of appetite					Weight gain or loss				
Apathy or lack of motivation					Suicidal thoughts or attempts				

Symptom	0	1	2	3	Symptom	0	1	2	3
Substance abuse					Feelings of worthlessness				
Headaches/stomach pain					Social isolation				
Guilt/Shame					Poor attention or focus				
Hyperactivity					Self-esteem issues				
Mood swings					Unusual or racing thoughts				
Anger					Aggression/violence				
Anxiety or worry					Panic attacks				
Phobias					Obsessions				
Compulsive behavior					Victim of abuse or trauma				
Feeling detached or distant					Hearing or seeing things				
Self-harming or cutting					Difficulty making/keeping friends				
Exposure to domestic violence					Legal trouble				
Learning difficulties					Tolieting issues				
Behavior concerns at school					Tantrums/fits				
Poor grooming					Irritability				
Binging/purging					Anorexia				
Tearfulness					Chronic medical condition				
Defiance/oppositional behavior					Victim of a crime				
Nightmares					Other: ___________________				
Other: ___________________					Other: ___________________				

Psychiatric Treatment History:

Has your child seen a psychiatrist in the past? Yes No Name/phone:_________________________________

Is he or she currently seeing a psychiatrist? Yes No Name/phone: ___________________________________

Current medications and supplements, along with dosage: ____

____

Has your child been hospitalized for emotional, psychological or substance use issues? Yes No

If yes, when and for how long:____

Location/Facility name: ____

Has anyone else in your family had similar psychological or emotional difficulties and/or concerns?

Please explain.____

____

____

Developmental History:

Were there any complications with the pregnancy and delivery of your child? ______ If yes, explain.__________

____

____

____

Have you or anyone else had concerns about your child's development? ________ If yes, explain.___________

____

____

____

Have you or anyone else had concerns about your child's social development? ____ ____ If yes, explain.______

____

____

____

Have you or anyone else had concerns about the intellectual or academic functioning of your child? __________

If yes, explain.____

____

____

____

Substance Use Inventory:

Please indicate if your child has used or is currently using the following substances. Please list other family members who have used or are currently using.

	Age of child's first use	When last used	Current frequency and amount	Previous treatment	Family members with past or current use issues.
Alcohol				Yes No	
Marijuana/ Hashish				Yes No	
Meth/ "Speed"				Yes No	
Cocaine/ Crack				Yes No	
Heroin				Yes No	

	Age of child's first use	When last used	Current frequency and amount	Previous treatment	Family members with past or current use issues.
Prescription drugs				Yes No	
Inhalants				Yes No	
Ecstasy/ Molly				Yes No	
Mushrooms				Yes No	
Caffeine				Yes No	
Nicotine				Yes No	
Other:				Yes No	
Other:				Yes No	

Cultural and Spiritual History:

Cultural identity: ____________________________Spiritual identity: ____________________________________

Importance of spirituality/religion: Low Med High

Is your child or family currently active in your community? _____If so, describe: ___________________________

____

____

Does your child or family currently engage in spiritual activities? _____If so, describe: ______________________

____

Socio-Economic History:

<table>
<tr>
<td>Living Situation:

☐ Housing adequate
☐ Homeless
☐ Housing overcrowded
☐ Housing dangerous / deteriorating
☐ Living companions unstable

Employment:

☐ Employed & Satisfied
☐ Employed but Dissatisfied
☐ Unemployed
☐ Conflicts at work
☐ Unstable work history
☐ Disabled
☐ Student / underage</td>
<td>Family Finacial Situation:

☐ No current financial stress
☐ Large debt
☐ Low income
☐ Impulse spending
☐ Relationship conflict over money

Family's Social Support System:

☐ Supportive network of friends and family
☐ Few friends
☐ New to the area
☐ No friends
☐ Geographically or emotionally distant from family</td>
<td>Parental Legal History:

☐ No legal problems
☐ Parole / probation
☐ Arrest(s) not substance related
☐ Arrest(s) substance related
☐ Jail / Prison time

Last legal difficulty:______________

_______________________________</td>
</tr>
</table>