LINDA BERLIN, PSY.D. & PSYCHOLOGICAL ASSOCIATES, P.A.

CLINICAL PSYCHOLOGY – GENERAL PSYCHIATRY – CHILD AND ADOLESCENT PSYCHIATRY

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CHILD & ADOLESCENT PATIENT HISTORY FORM

Provider: Michelle F. Albo, LMHC, MCAP
Licensed Psychotherapist
Master's Certified Addictions Professional
EMDR Trained

Appointment Date ____/____/____
Today's Date ____/____/____

******Please star (*) or circle any information you would like to discuss without your child present.**
Please fill out and bring to first appointment.

Caregiver completing this form (name and relationship):	

IDENTIFICATION					
Patient's Name:		**Home Address:**			
Nickname:					
Who referred patient to this office?		**Phone 1:**		**Phone 2:**	
Primary Care Physician:		**Parent Email Address:**			
Physician's Phone:		**Physician's Address:**			
Is it okay to have contact with Physician if necessary? Release signed?	**Yes**	**No**	**Unsure**		
Primary Reason(s) for Referral? Concerns?					

PATIENT'S BACKGROUND INFORMATION/FAMILY DYNAMICS					
Date of Birth:		**Age:**		**Gender:**	
Ethnicity (circle all that apply):	**African-American**	**Asian-American**	**Hispanic**	**Native American**	**Caucasian** **Other:** _____
Religious preference:					
Biological parents are:	**Married**	**Engaged**	**Separated**	**Divorced**	**Never married**
*******If biological/adoptive parents are NOT living in the same home, please fill out the accompanying Parent Relationship Status Questionnaire.**					

Primary Caregiver name:				**Secondary Caregiver name:**			
Biological	**Step**	**Adoptive**	**Foster/Guardian**	**Biological**	**Step**	**Adoptive**	**Foster/Guardian**
Home Phone:		**Work Phone:**		**Home Phone:**		**Work Phone:**	
Place of employment:				**Place of employment:**			
Occupation:				**Occupation:**			
Work schedule:				**Work schedule:**			

Other parents living in the home, siblings, brothers, sisters, etc…..	Name	Age	Gender	Relationship to patient?

Other individuals regularly involved? (grandparents, non-custodial parent/step-parent)	Name	How often?	Relationship to patient?

MEDICAL AND DEVELOPMENTAL INFORMATION

Did you and/or your doctor note any problems with pregnancy?	Yes	No	Unsure
Did you and/or your doctor note any problems with delivery?	Yes	No	Unsure
Any concerns with drug/alcohol abuse, tobacco use, or high blood pressure?	Yes	No	Unsure
What is your general impression of your child's development during infancy?			

Indicate when your child achieved the following activities (enter age when skill was acquired or indicated if you felt it was *normal* or *delayed*)

Sat alone (ave 6-8 mos)		Crawled (ave 9 mos)		Walked (ave 12-18 mos)	
Fed self (ave 10-12 mos)		Spoke words (ave 10 mos)		Toilet trained (ave 2-3 yrs)	

Does your child have any physical health problems that may interfere with normal functioning (vision, hearing, motor)?	Yes	No	Unsure	
If yes, please briefly describe:				
Any hospitalizations, surgeries, emergency room visits?	Yes	No	If yes, please briefly describe:	
Any current health concerns?	Yes	No	If yes, please briefly describe:	
Current medications for patient? Prescribing dr…..?				
Allergies?				

MENTAL HEALTH HISTORY

Has your child every received counseling services or psychotherapy?	Yes	No				
If yes, please list:	Dates	Provider	Diagnoses	Dates	Provider	Diagnoses

Have any family members received counseling services or psychotherapy in the past?	Yes	No	
If yes, please briefly describe:			
Does your child have a history of substance abuse?	Yes	No	Unsure
If yes, please briefly describe:			
Do any family members have a history of substance abuse?	Yes	No	Unsure
If yes, please briefly describe:			

What are your child's talents/skills? Any extracurricular activities?	
What are your child's weaknesses?	

SCHOOL INFORMATION					
Currently attends school?	**Yes**	**No**	**Attended school last year?**	**Yes**	**No**
Current grade level:			**If summer, grade child will be entering:**		
School name:			**Teacher's Name(s):**		
Current grades?			**Last reporting period?**		
Has the child ever been suspended, expelled, or retained in a grade?			**Yes**	**No**	
Has the child ever received early intervention or special education services? Or receive Speech, Occupational, or Physical Therapy at School?			**Yes**	**No**	
Does your child have an IEP or Section 504 Plan? Please describe?					

ADDITIONAL INFORMATION			
Does the child have a legal history or offender issues?	**Yes**	**No**	**Unsure**
If yes, please describe:			
Do other family members have a legal history or offender issues?	**Yes**	**No**	**Unsure**
If yes, please describe:			

PARENT RELATIONSHIP STATUS QUESTIONNAIRE

******Please fill this questionnaire out if biological/adoptive parents are not living in the same home*******

Biological/adoptive parent completing this form (name and relationship):	

ADDITIONAL INFORMATION			
Biological/adoptive parents' relationship status? (please circle one and fill in additional information as necessary)	**Separated** **Date: _____**	**Divorced** **Date: _____**	**Never lived together**
	Other: _____		
Name of biological/adoptive parent not living in the home:		**Biological**	**Adoptive**
Home Address:			
Home Phone:		**Place of employment:**	
Occupation:		**Work Phone:**	
What is the current custody agreement? Has this always been the arrangement? If not, what was the agreement previously and why was it changed (e.g., court ordered change)?			
Does your child's other biological/adoptive parent know the child is here today?			

Does your child's other biological/adoptive parent agree with you bringing the child in?	
How often does the non-custodial biological/adoptive parent have contact with the child?	
What type of contact (e.g., phone, visitations)?	
How do you communicate with your child's other biological/adoptive parent?	
How difficult is it for you and your child's other biological/adoptive parent to reach decisions related to school, activities, medical decisions?	
How flexible are you when it comes to visitations?	
Do you have disagreements in front of your child?	
Any other information you feel is important?	

SYMPTOMS CHECKLIST: PLEASE CIRCLE THE BEHAVIORS THAT APPLY TO YOUR CHILD'S PRESENT CONCERNS.	**Argues, talks back** **Overweight** **Cruel to Animals** **Does not Follow Rules/Disobedient** **Skips School** **Refuses to Speak** **Poor Relationships with Family** **Self-Harming Behaviors** **Tics** **Inflexible Rigid** **Wetting Bed or Soiling Clothes** **Experienced/Witnessed Traumatic Incident** **Impulsive** **Distractible, Inattentive** **Problems with Organization and/or Managing Time** **Poor Grades** **Rocking or Repetitive Movements**	**Cries Easily, Feelings Easily Hurt** **Cheats/lies** **Sad/Unhappy** **Fearful/nervous** **Disordered Eating Patterns (restricts food, binges, overeats)** **Fighting, aggressive behavior)** **Hyperactive** **Irritable/easily frustrated** **Nail biting** **Running Away** **Inappropriate Sexual Behaviors** **Daydreams** **Fire Setting** **Speech Difficulties** **Strange Ideas/Bizarre Thoughts** **Problems Making/Keeping Friends**	**Poor Grades** **Impulsive** **Poor Sleep** **Drug or Alcohol Abuse** **Immature, prefers younger playmates** **Teased or Picked on** **Problems Learning** **Complains of Feeling Sick Often** **Withdrawn** **Mood Instability** **Suicidal Statements, Thoughts, or Attempts** **Legal Problems** **Intellectual Disability/low IQ** **Nightmares** **Shy/Timid**
Parent Signature: **Date Signed:**			
