New Day Psychology, LLC

CLIENT INFORMATION FORM – CHILD/ADOLESCENT

Child's Full Name: _____ Today's Date: _____
Date of Birth: _____ Age: _____ Gender: _____
Address:_____
(Street) (City) (State) (Zip code)
School: _____ Grade: _____
(Name) (City)
Parent Mother/guardian Name: _____* **Date of Birth:**_____
Address:_____
***If Different from Child's** (Street) (City) (State) (Zip code)

Parent Father/guardian Name: _____* **Date of Birth:**_____

Address:_____
*If Different from Child's (Street) (City) (State) (Zip code)

Parent's marital status: _____
Step-mother: _____ Step-father: _____
Current custody arrangement (if applicable): _____
_____

Please list other Parents/Step parents/Guardians/other important family members (not siblings):

Name	*Relationship*	*Age*	*History of illness (physical/mental)*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I may be contacted by:

Text: Yes No Mother's Cell phone: _____ Father's Cell phone: _____

Email: Yes No Mother/Guard. Email: _____ Father/Guard. Email: _____

Home: Yes No May I leave a message on the answering machine? Yes No

If Different:

Mother Home phone: _____ Father Home phone: _____
Work: Yes No **Work:** Yes No
Work phone: _____ Work phone: _____
Others - Leave a message/call _____relationship_____ at this number_____
Please list any restrictions: _____

Whom may I contact in case of an emergency?

Name: _____ Relationship: _____
Phone: _____ Alternate phone: _____

580 Roger Williams Ave. suite #22
Highland Park, IL 60035
1-847-980-8707
E-Mail: dr.vdor@gmail.com

PLEASE COMPLETE THE FOLLOWING:
In the space below, please briefly describe:

The Reason(S) For Seeking Services for Your Child:

_____
_____
_____
_____

When did this Issue Begin: _____
Has Your Child Ever had Previous Counseling or Psychotherapy? Yes No
If "Yes," By Whom _____
How long Ago and for how long: _____
Was it successful?_____
Reason termination: _____

FAMILY INFORMATION:

Please list siblings (full/half/step) siblings in order of age:

Name	Relationship	Age	History of illness (physical/mental/alcohol/drugs)

Other People Living In the Home: _____

Primary language spoken in the home: _____ Secondary: _____

Non-residential adults involved with your child (e.g., nanny/ babysitter): _____
_____

DEVELOPMENTAL/MEDICAL INFORMATION:

Around what age did your child achieve these milestones? You can also write: Normal/ Delayed

Crawled_____ Walked _____ Said first words_____ Toilet trained_____

Any learning difficulties? Yes No (Describe)_____
Has your child ever received services from a speech pathologist? Yes No
Has your child ever received services from a physical therapist? Yes No
Has your child ever received services from an occupational therapist? Yes No
Does your child have sensory issues? Yes No *If yes:* Taste Noise Cloths labels/seams other_____

Has your child ever been evaluated for a special education or Section **504 plan**? Yes No

Does your child have a current **IEP**? Yes No Primary Issue:_____ Secondary_____

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Describe Any Major Illnesses, Injuries, Or Surgeries?

Illness	Hospitalized *(yes/no)*	Date	Lasting Effects if any?

Has your child ever had a concussion or serious head trauma? Yes No

Has your child ever had a seizure? Yes No

Current Medications:

Medication name	Dosage	Medication name	Dosage

Name of Psychiatrist: _____ **Phone**: _____

Address:_____

Are You Giving Me Permission to Communicate With the Psychiatrist: Yes No

Have you ever been psychiatrically hospitalized? Yes No

List Hospitalizations:

Hospital	Month/Year	Length of stay	Reason for hospitalization

Is The Child Currently Saying She/He Wants Die? Yes No
If Yes, Does He/She Shared a Plan Yes No
If Yes: Details_____
Have Your Child Ever Made A Suicide Attempt/Gesture? Yes No
Details:_____
Family/Current Physician_____**Phone:**_____
Special Diet? _____
If - What Allergies Does the Child Have?_____

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Please Use The Scale Below to Indicate Your Child's Current Level of Distress with the Following Items:

	No Concern	Mild	Moderate	Urgent
Academic problems	0	1	2	3
Aggressive behavior	0	1	2	3
Self-Harm	0	1	2	3
Anxiety/fears/worries	0	1	2	3
Attention/concentration difficulties	0	1	2	3
Bedwetting	0	1	2	3
Behavior problems	0	1	2	3
Change in family constellation (e.g. divorce or remarriage)	0	1	2	3
Depression	0	1	2	3
Eating problems	0	1	2	3
Feelings over a recent loss/death	0	1	2	3
Losing contact with reality	0	1	2	3
Relationship with parent/s	0	1	2	3
Relationship with sibling/s	0	1	2	3
Relationship with peers	0	1	2	3
Problems with alcohol	0	1	2	3
Problems with drugs/ meds/substances	0	1	2	3
Sexual behaviors	0	1	2	3
Sleep problems	0	1	2	3
Suicidal feelings/behaviors	0	1	2	3
Trauma/Physical or sexual abuse	0	1	2	3

Other (not listed above):_____

_____

Childs' Strengths:_____

_____

_____

_____

Please list hobbies, sports, recreational, TV, and toy preferences; any special skills or talents:

_____

_____

_____

_____

***If Appropriate and Possible Please Let your Child Fill the Next 2 Sections:**

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Which Best Describes You? **(Please Fill All Following Statements).**

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✓" to indicate your answer"*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score _____ = **Column totals: ___ + ___ + ___ + ___**

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

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Which Best Describes You? **(Please Fill All Following Statements).**

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer"*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.....……	0	1	2	3
2. Feeling down, depressed, or hopeless.……..……	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.....……..……..	0	1	2	3
4. Feeling tired or having little energy.....……..……	0	1	2	3
5. Poor appetite or overeating.....……..…	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down……..	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television……..	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving .around a lot more than usual.....……..	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.....……	0	1	2	3

Total Score _____ = Column totals _____ + _____ + _____ + _____

***If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**

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