



# 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):

<i>Name</i>	<i>Relationship</i>	<i>Age</i>	<i>History of illness (physical/mental)</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### 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: \_\_\_\_\_



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Phone: \_\_\_\_\_

Alternate phone: \_\_\_\_\_

## **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:

<u>Name</u>	<u>Relationship</u>	<u>Age</u>	<u>History of illness (physical/mental/alcohol/drugs)</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**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 \_\_\_\_\_



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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 \_\_\_\_\_

### Describe Any Major Illnesses, Injuries, Or Surgeries?

<u>Illness</u>	<u>Hospitalized (yes/no)</u>	<u>Date</u>	<u>Lasting Effects if any?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Has your child ever had a seizure? Yes No

### Current Medications:

<u>Medication name</u>	<u>Dosage</u>	<u>Medication name</u>	<u>Dosage</u>

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:

<u>Hospital</u>	<u>Month/Year</u>	<u>Length of stay</u>	<u>Reason for hospitalization</u>

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: \_\_\_\_\_



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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:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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**\*If Appropriate and Possible Please Let your Child Fill the Next 2 Sections:  
Which Best Describes You? (Please Fill All Following Statements).**

## GAD-7

<b>Over the last 2 weeks, how often have you been bothered by the following problems? <i>(Use "✓" to indicate your answer"</i></b>	<b>Not at all</b>	<b>Several days</b>	<b>More than half the days</b>	<b>Nearly every day</b>
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**

<b>Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer"</b>	<b>Not at all</b>	<b>Several days</b>	<b>More than half the days</b>	<b>Nearly every day</b>
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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580 Roger Williams Ave. suite @21 #22  
Highland Park, IL 60035

Page 8 of 8

\*Phone: **847-748-0005**

\* E-Mail: [dr.vdor@gmail.com](mailto:dr.vdor@gmail.com)

\*Fax: 847-282-1650

\*[dr.astridhesse@gmail.com](mailto:dr.astridhesse@gmail.com)