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The following information is requested by Selby Psychological Services (SPS) to best serve your minor child (please see applicable information in our Outpatient Services Contract regarding minors). Please clearly print your response to each question. This will help save time in your child's first session. ***Some parts may not be applicable to a younger child, but may be applicable to an older teenager (e.g., substance abuse information), if an area is not applicable please denote it as N/A*****. If you are unable to complete some parts, then leave them blank and you will have a chance to complete them with your psychologist. Case records are strictly confidential.**

SECTION I: IDENTIFYING INFORMATION Today's Date: _____

Name_____ Date of Birth_____

Address_____ City/State_____ Zip_____

Social Security Number_____

Age____ Gender: F___ M___

Home Phone_____ Work Phone_____ E-mail _____

Marital Status_____ Employment_____

Emergency contact_____ Relationship _____

Home Phone_____ Work Phone_____

Who Referred You? _____

If you are Self Referred, how did you hear about Selby Psychological Services?_____

Primary Care Provider_____ Phone Number_____

Other Mental Health Provider (if any) _____ Phone Number _____

Name of Insured:_____ Gender _____

Insured's Street Address:_____

Patient's Relationship to Insured:_____Insured's Birth Date_____

Insurance Carrier: _____

Insurance ID Number _____

SECTION II: DESCRIPTION OF PRESENTING PROBLEM

Please describe why you decided to seek services at SPS for your child:

Please tell us what you want your child to work on or change in psychotherapy:

How long has this been a significant problem for your child (Please be specific)?

How would you estimate the severity of the problem at this time? (Please check the box that best represents the severity)

Mild-☐ ☐ ☐ ☐ Moderate-☐ ☐ ☐ ☐ Serious-☐ ☐ ☐ ☐ ☐ Severe

What symptoms are related to this problem? Please check **all** that apply for your child **now**:

☐ overeating	☐ theft/destruction of property	☐ rapid heart rate	☐ compulsive behaviors
☐ taking drugs	☐ depressed mood	☐ learning difficulties	☐ fears/phobias
☐ odd behavior/thoughts	☐ crying	☐ trembling or shaking	☐ anxiety
☐ recent weight gain	☐ difficulty concentrating	☐ worrying	☐ vomiting
☐ recent weight loss	☐ low motivation	☐ toileting problems	☐ distrust
☐ recent appetite changes	☐ aggressive/angry behavior	☐ lying	☐ jumpiness
☐ social withdrawal	☐ feelings of worthlessness	☐ nightmares	☐ restricting food
☐ suicidal thinking	☐ impulsive/risky behavior	☐ language difficulties	☐ fatigue/loss of energy
☐ hyperactivity	☐ sleeping too much	☐ decreased need for sleep	☐ obsessions
☐ difficulty falling asleep	☐ problems at school	☐ non-compliance	☐ social problems
☐ difficulty staying asleep	☐ inattention/easily distracted	☐ drinking alcohol	☐ other: _____
☐ experienced a traumatic event	☐ defiance		

If applicable, please describe any incidents or problems that may have contributed to this problem (e.g., problem with work, family relationship ending, divorce, past trauma, etc.):

In the past, what has been helpful to your child in dealing with this problem?

SECTION III: MEDICAL HISTORY

Please list any significant past or current **health, medical, or psychiatric issues** (including anything resulting in hospitalizations) for your child.

Dates /Problem/ Treatment/ Hospitalized (Y/N)

Has your child **ever had treatment by**, or is your child **currently seeing**, a psychiatrist, psychologist, therapist, or counselor?

Yes ☐ No ☐

Problem/ Where /When/ Therapist/ Helpful (Y/N)

Has your child ever been given a mental health diagnosis in the past from a mental health professional? Yes ☐ No ☐

If yes, as you understand it, what is/was that diagnosis? _____

SECTION IV: MEDICATIONS AND SUBSTANCES USED If applicable, please list all medications your child is now taking or has taken in the past three months, **including birth control pills, vitamins, herbs and supplements**.

Medications/Dosage/Prescribing Provider/Length of prescription/Helpful (Y/N)

Other Drugs/Substances Used (Alcohol/Illicit or other) /How long has your child/teen been using this substance?

How many caffeinated beverages does your child drink per day? _____

Of what type?_____