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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 \_\_\_\_\_

Insured's Social Security #: \_\_\_\_\_ Insurance Carrier: \_\_\_\_\_

Employer and/or Group # of plan: \_\_\_\_\_

Insurance ID (if different from Social Security 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? (Place "X" on the line below)

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

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

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