Fulton Psychological Group

CHILD INFORMATION

Name of Child:_____ Date:_____

Home Address:_____
Street City Zip Code

Birth Date:_____ School:_____

Grade:_____ Teacher:_____

Name of Parent:_____ Occupation:_____

Home Address: _____

Home Phone #:_____ Work Phone #:_____

Cell Phone #:_____ E-mail:_____

Name of Parent:_____ Occupation:_____

Home Address: _____

Home Phone #:_____ Work Phone #:_____

Cell Phone #:_____ E-mail:_____

Child's Previous Therapy:_____
Therapist's Name Period of Time Therapy Issue

Physician:_____ Phone #:_____

Please describe your living arrangements:

_____ _____
Name Age Relationship Name Age Relationship

_____ _____
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In case of emergency notify:_____ Phone #:_____

Initial here if you are forwarding your invoices to your insurance company for reimbursement: _____
If so, please provide an e-mail address to receive invoices: _____.

Who referred you to my practice?_____
It is customary to thank the referring person. **Your signature below gives me permission to contact and thank this person**. No other information will be disclosed.

Signature:_____ Date:_____

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Why are you seeking services for your child at this time? _____

_____

_____

_____

Check any symptoms your child has exhibited in the past six months:

___ Sadness/Crying Spells
___ Socially Isolated
___ Appetite/Weight Loss
___ Insomnia
___ Excessive Sleep
___ Giving Up Easily
___ Difficulty Having Fun
___ Excessive Anger/Hostility
___ Suicidal Thoughts/Statements
___ Difficulty with Authority Figures
___ Often in Trouble
___ Argumentative
___ Nervousness/Jittery
___ Irritable/Temper Outbursts
___ Persistent Thoughts
___ Mood Swings
___ Excessive Worrying
___ Fidgety
___ Excessive Nightmares
___ Difficulty Sleeping in Own Bed
___ Very Active
___ Easily Distracted
___ Has Conflicts with Peers
___ Doesn't Follow Directions
___ Other (please describe): _____

List and describe any history of emotional disorder(s) in your child's biological family:

_____

_____

List and describe any significant life events (e.g. divorce, death in family, etc.):

_____

_____

How does your child function at school (i.e. grades, with peers, with teachers)?

_____

_____

List and describe your child's current or historical physical problems (e.g. weight gain, headaches, etc.):

_____

_____

List any medication(s) and dosage your child is currently prescribed: _____

_____

What are your child's strengths and hobbies? _____

_____