



# 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

Name Age Relationship Name Age Relationship

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: \_\_\_\_\_

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

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

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

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

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

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

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

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

What are your child's strengths and hobbies? \_\_\_\_\_

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