INTEGRATIVE PSYCHIATRY & PSYCHOTHERAPY

Felicity Sanders, PhD

New Patient Information:
Child/Adolescent

To be completed by the parent or guardian requesting treatment

INTEGRATIVE PSYCHIATRY & PSYCHOTHERAPY PLLC
161 MAGNOLIA SQUARE COURT • ABERDEEN NC • 910.757.0714

NEW PATIENT INFORMATION: Child/Adolescent

(To be filled out by the parent or guardian requesting treatment.)

Child Information

What does your child prefer to be called _____

School_____ Grade_____

Primary Custodian of minor child_____

Mother's Information:

Name (first, mi, last) _____ Marital Status _____ Race_____

Street address_____

City, State, Zip_____

Occupation_____ Place of Employment_____

Please circle one: biological mother, stepmother, adoptive mother, foster parent, other/guardian

Father's Information:

Name (first, mi, last) _____Marital Status _____ Race_____

Street address_____

City, State, Zip_____

Occupation_____ Place of Employment_____

Please circle one: biological father, stepfather, adoptive father, foster parent, other/guardian

Who referred you to this practice_____

Person to be notified in the event of an emergency:

Name_____ Phone_____

Who filled out this information form? _____

BROTHERS & SISTERS IN THE HOME:

Name	Age	Grade/Occupation	Relat to Child

RELEVANT MEDICAL HISTORY:

Pregnancy and Delivery: Planned[ ] Unplanned[ ] Normal[ ] Complications[ ]

Explain: _____

Birth Weight: _____lbs ____ozs.

Medical Complications (First Year) _____

Health: Seizures[ ] Head Injuries[ ] Diabetes[ ] Surgery[ ] Asthma[ ]

Allergies[ ] Headaches[ ] Other[ ]

Explain: _____

Developmental Milestones:

Age: _____Walked _____Talked _____Toilet-trained

Comments: _____

Current Medications: _____

Sleep Disturbances (nightmares, early/intermittent awakenings): _____

Appetite Change (increase, decrease, same): _____

Weight Change (increase, decrease, same; over what period of time): _____

Physical Complaints (headaches, stomach aches, vomiting): _____

EDUCATION HISTORY:

Pre-School:_____

Age began:_____

Social Adjustment:_____

Separation Problems:_____

School History and Functioning:

Age began:_____

Social Adjustment: _____

Separation Problems: _____

Academic Adjustment (include average grades): _____

Conduct in School: _____

Special Placement: _____

Repeated Grades (specify grade and reason): _____

_____

1) Please describe your reasons for seeking treatment for your child at this time. Include any important events that have lead to your decision to seek treatment at this time.

2) List other counseling, therapy, or psychiatric treatment that your child has ever had.

3) List other family members who have received mental health treatment and why.

4) Who is your child currently living with?

5) Describe parents'/caretaker relationship with each other.

6) Describe your child's relationship with each parent/caretaker.

7) What are your child's leisure activities?

8) Are you involved in a church? If so, which faith and what is your involvement?

9) Has your child ever been physically or sexually abused or assaulted?

10) Do you have any concerns regarding your child's drinking or substance abuse? If yes, please explain why.

11) Do you have any concerns about your child taking her/her own life? If yes, please explain why.

12) Has your child ever intentionally hurt him/herself (e.g., cutting or hitting self)? If yes, please explain.

13) Do you feel your child is able and willing to benefit from psychological therapy at this time? Why or why not?

14) Do your friends and family agree with your decision to seek treatment for your child at this time?

Please circle any of the following that has affected your child:

Depression. Insomnia. Sleeping too much/little. Nightmares. Weight loss or gain. Fatigue.
Crying spells. Difficulty concentrating. Excessive cleanliness. Overly strong habits. Racing thoughts.
Fears of: heights, closed spaces, animals, crowds, elevators, school, leaving the home.
Overly repetitive thoughts. Bad thoughts. Criminal record. Excessive temper. Fighting.
Physical abuse/assault. Sexual abuse/assault. Drug or alcohol abuse. Suicidal thoughts.
Suicide attempts. Periods of intense anxiety. Periods of difficult breathing or tightness in the chest.
Hallucinations. Poor memory. Suspension from school. Expulsion from school. Bed-wetting.
Sexually inappropriate behavior. Temper tantrums. Obscene language. Fire-setting.
Physical cruelty to animals. Shyness.

Please circle any of the following that has affected anyone who is related to you.

Depression. Insomnia. Sleeping too much/too little. Weight loss or gain. Fatigue. Crying spells. Difficulty concentrating. Bad nerves or nervous breakdown. Excessive cleanliness. Fears of heights, closed spaces, animals, crowds, elevators, leaving the home. Overly strong habits. Racing thoughts. Overly repetitious thoughts. Bad thoughts. Bankruptcy. Impulsive spending. Criminal record. Excessive temper. Fighting. Physical or sexual abuse. Drug or alcohol abuse. Suicidal thoughts or attempts.

Please note anything else that your child's therapist should know (please use the back side if needed.