COMPREHENSIVE PSYCHOLOGICAL SERVICES, P.C.

INFORMATION AND HISTORY

I. Child and Adolescent Identifying Information

Client's Name:_____ Date:_____

Date of Birth:_____ Age:_____ Gender: _____

Address: _____ (city)_____ (zip)_____

School:_____ Grade:_____

Phone: _____ Alternate Phone: _____

Parents' Names and Addresses:

Mother:_____
_____ Primary Phone:_____

Father:_____
_____ Primary Phone:_____

Stepmother (if applicable):_____
_____ Primary Phone:_____

Stepfather (if applicable): _____
_____ Primary Phone:_____

II. Insurance

Insurance:_____ Subscriber:_____ DOB:_____

Contract/Member ID:_____ Relationship to Client: _____

Group Number: _____ Social Security #: _____

Secondary Insurance:_____ Subscriber:_____ DOB:_____

Contract/Member ID:_____ Relationship to Client: _____

Group Number:_____ Social Security #: _____

III. Clinical Information

Please explain why you are seeking psychological services for your child at this time: _____

_____

_____

_____

Has your child received outpatient psychological services in the past? Y N

Please describe: _____

Has your child ever been hospitalized for psychiatric reasons? Y N

Please describe: _____

Has your child expressed any thoughts of hurting self or others? Y N

Please describe: _____

Has your child ever been evaluated by a school psychologist or other educational specialist? Y N

Please describe: _____

Has your child ever been diagnosed with a psychiatric, developmental, or learning problem? Y N

Please describe: _____

_____

_____

IV. Substance Abuse History

Do you have any reason to believe your child has used non-prescription drugs or alcohol in the past? Y N

Please describe: _____

_____

_____

_____

V. General Health History

How is your child's overall health now? poor fair good excellent

How has it been most of his/her life? poor fair good excellent

In the past 6 months:

has your child been treated by a physician for any illnesses? Y N

please describe:_____

has child's appetite changed? decreased increased no change

has child's weight changed recently? lost_____lbs gained_____lbs no change

has child's overall "energy" changed? decreased increased no change

Does your child usually have trouble sleeping? Y N

Is your child currently taking any medications? Y N

Please list medications and dosages:_____

Physician's Name and Phone Number: _____

VI. Illnesses and Medical Problems

Please check (✔) any of the following illnesses and medical problems your child has had and indicate the year when each started or occurred. If you are uncertain when an illness started, please give an approximate year.

illness	✔	year	illness	✔	year
Vision problems			Joint pain		
Eye disorder			Stomach problems		
Ulcers			Yellow jaundice		
Hearing problems			Breath-holding spells		
Ear Infections			Encephalitis		
Bronchitis			Hernia		
Neurological Disorder			Kidney or Bladder Disease		
Pneumonia			Accidental poisoning		
Allergies			Headaches		
Asthma			Epilepsy		
Genetic Disorder			Bedwetting		
Meningitis			Night terrors		
High blood pressure			Encopresis		
Seizure disorder			Enuresis		
Measles			Cancer		
Mononucleosis			Diabetes		
Heart murmur			Hepatitis		
Other heart condition			Other		

Parent/Guardian Signature:_____ **Date:**_____