Charlotte Tilson, Psy.D.
Psychologist

Confidential Client Information – Children & Adolescents

Welcome to my practice. Please complete this form as fully as possible and bring it to your initial parent appointment. To protect your and your child's privacy, please do not email me the completed form. I look forward to meeting you.

Today's Date:

Child's Name:

Date of Birth: Age:

Gender: Ethnic/Cultural Background:

School: Grade:

Your Name: Relationship to the child:

Age: Gender:

Occupation/Employer: Ethnic/Cultural Background:

Home Address:

City/State/Zip Code:

Cell Phone #: ☐ OK to call? ☐ OK to leave message?

Home Phone #: ☐ OK to call? ☐ OK to leave message?

Work Phone #: ☐ OK to call? ☐ OK to leave message?

Email: ☐ OK to email?

Will you be requesting a bill? If yes, please indicate if bill is for:

☐ Insurance (requires a diagnosis)

☐ Flex Spending Account (FSA) or Health Savings Account (HSA)

Parent(s) Relationship Status:

If applicable, please describe your current custody arrangement (legal custody, physical custody etc.):

If applicable, please provide information for the child's other parent.

Name: Relationship to the child:

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Stepparent(s) name(s) (if applicable):

Referral Information

How did you hear of my practice? ☐ Word of mouth ☐ Internet search
☐ psychologytoday.com ☐ goodtherapy.org ☐ Yelp
Other:

What brings you in today?

When did these difficulties begin? Did any particular event seem to trigger them?

Is your child struggling with any of the following? Please check any that apply.

☐ Sad/Depressed Mood	☐ Sleep Issues	☐ Shyness
☐ Worries/Anxiety	☐ Hyperactivity	☐ Hearing Voices
☐ Withdrawn	☐ Nightmares	☐ Social Skills
☐ Physical Aggression/Fighting	☐ Academic Performance	☐ Seeing Things Others Do Not See
☐ School Attendance	☐ Bullying	☐ Inappropriate Sexual Behavior
☐ Irritability	☐ Oppositional/Defiant	☐ Conflicts in Family Relationships
☐ Bereavement	☐ Stealing	☐ Alcohol/Drug Use
☐ Parental Divorce/Separation	☐ Self-Injurious Behavior	☐ Wetting/Soiling Bed/Pants
☐ Trauma	☐ Suicidal Thoughts	☐ Repetitive Behaviors
☐ Developmental Delays	☐ Lying	(such as hand washing)
☐ Running Away	☐ Excessive Clinging	☐ Difficulty Relating to Peers
☐ Decreased/Increased	☐ Poor Attention/	☐ Restricted Eating/
Appetite	Concentration	Binging or Purging
☐ Anger management	☐ Grief/Loss	☐ Gender/Sexual Identity Issues
☐ Substance use/abuse	☐ Health Issues	☐ Challenges with Friends

The pain and distress caused to my child by his/her problem(s) is:
☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

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The pain and distress caused to others by my child's problem(s) is:
□ Very Mild □ Mild □ Moderate □ Severe □ Very Severe

How many sessions do you think would be needed to successfully resolve the current concerns?
□ 1-10 □ 10-20 □ 20 or more □ Ongoing, longer-term therapy

After counseling or consultation, I expect my child's problem to be:
□ Slightly Better □ Moderately Better □ Mostly Better □ Completely Better

Family
Who lives at home with your child?

Please provide the name(s) and age(s) of your child's sibling(s) or step sibling(s).

Language(s) spoken at home:

Have there been any deaths or separations from people with whom the child had a close relationship or frequent contact? If yes, please explain.

Have any family members had emotional/mental health/psychiatric issues (anxiety, depression, issues with attention, learning, issues related to trauma, OCD etc.)? If yes, please indicate the relationship to the child and the nature of the issues.

Have any family members had problems with alcohol or drugs? If yes, please describe.

Development
If your child was adopted, please fill out the information below as best as you can and continue on to the next section.

Please describe any complications the child's mother had during pregnancy or delivery.

Child was born:
□ Pre-term
By how much?
□ Full Term
□ Post-term
By how much?

Did the mother have:
□ "Baby Blues"
□ Postpartum Depression
□ Receive treatment for the preceding?

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Any concerns in these areas regarding your child's development from 0-5?

☐ Excessive Crying	☐ Hyperactivity	☐ Speech
☐ Feeding Problems	☐ Sleep	☐ Hearing
☐ Movement	☐ Social relatedness	☐ Vision
☐ Other:		

School

How is your child doing at school or child care?

Does your child have social or behavioral problems at school?	☐ Yes	☐ No
Does your child have learning problems at school?	☐ Yes	☐ No
Has your child ever been kept back or put ahead at school?	☐ Yes	☐ No
Is your child receiving special education services/have an IEP or 504 Plan?	☐ Yes	☐ No
Has your child had tutoring/is he/she currently in tutoring?	☐ Yes	☐ No

Health & Lifestyle

Pediatrician's name: Psychiatrist's name:

Does your child have any current or past medical concerns? Vision or hearing issues? Disabilities or special needs? Has he or she had any head injuries? If yes, please explain.

Has your child experienced any hospitalizations or surgeries? If yes, please describe.

List your child's current medications (prescription, herbal and over the counter) including dosage.

What time does your child go to sleep and get up? If your child has sleep issues, please describe them.

Has your child ever received *other types* of therapy, such as speech therapy, occupational therapy or physical therapy? If yes, please describe.

Has your child ever received therapy/counseling or other mental health services? When and with whom?

Has your child ever had a psychological, psychoeducational or neuropsychological evaluation? If yes, please provide the name of the person/center who did the testing, approximate date of testing and/or provide a copy of the report(s).

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Has your child ever reported thoughts about or made statements about suicide/wanting to die, or attempted to hurt him/herself?

Has your child ever reported thoughts about, made statements about or attempted to seriously hurt someone else?

Has anyone in your family ever attempted suicide? If yes, please indicate relationship to the child.

Exposure to Violence

Has your child been exposed to violence, either as a witness or a victim?

If yes, indicate type: domestic violence, school violence, community violence, friend/family of victim …

Has your child feared for his or her physical safety in the last 3 months?

Was your child involved in any fights over the last 3 months?

Juvenile Court/Legal

Has your child been the victim of suspected or confirmed physical or sexual abuse or neglect?

If yes, were Children's Protective Services or the police involved?

Has your child experienced any placements, arrests, offenses, probation or incarceration?

Are you currently, or will you be involved in the near future, in the following situations that may require testimony, participation, or release of records from your therapist?

- ☐ Divorce or Separation
- ☐ Disability/Workers' Compensation
- ☐ Criminal Proceeding
- ☐ Other:
- ☐ Child Custody Proceeding
- ☐ Child Welfare Proceeding
- ☐ Civil Proceeding

Other

What are some adjectives that describe your child?

What are your child's areas of strength and interest?

What changes are you hoping for as a result of counseling or consultation? What do you think needs to be addressed first?

Please add any additional information you'd like to share. Thank you.

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