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Applied Psychological Health Services
Patient Info Sheet - CHILD

PLEASE PROVIDE THE FOLLOWING INFORMATION REGARDING YOUR CHILD:

Child's Name: _____ Date of Birth: _____

Who referred you to our practice? _____

Who is your child's primary physician? _____
Address: _____
Telephone: _____

What is your child experiencing that led you to seek assistance? _____

What medications is your child taking?

Name of Medication	Date Started	Dosage	Prescribed by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any over-the-counter medications, herbs, or other supplements your child takes:

Does your child have any allergies to medications? ___ Yes ___ No
Please list any allergies your child has: _____

Has your child ever been to a counselor, psychologist, or psychiatrist, or been admitted to a psychiatric hospital?
___ Yes ___ No. If "Yes", please list who your child saw, when, and for what purpose.

Where does your child attend school, and what grade are they in?

Are they receiving special education services? ___ Yes ___ No _____

Other people living in your home: _____

Whom can we contact in case of emergency? _____
Relationship _____ Phone: _____

If we need to call you, can we leave a message? ___ Yes ___ No

Does your child have friends his/her own age? Yes No
 Does your child complain of not having enough friends? Yes No
 Does your child play mostly with friends his/her own age? Yes No

Please list below if your child exhibits any of these problems:

- | | |
|--|--|
| <input type="checkbox"/> Poor Attention Span | <input type="checkbox"/> Temper Outbursts |
| <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Is Heedless to Danger |
| <input type="checkbox"/> Low Frustration Threshold | <input type="checkbox"/> Poor Memory |
| <input type="checkbox"/> Does not Listen when Spoken to | <input type="checkbox"/> Excessive Crying |
| <input type="checkbox"/> Excessive Number of Accidents | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> More Active than peers/siblings | <input type="checkbox"/> Sleep Walking |
| <input type="checkbox"/> Sulks/Pouts | <input type="checkbox"/> Excessively Fearful |
| <input type="checkbox"/> Abuse Directed Towards Others | <input type="checkbox"/> Nail Biting |
| <input type="checkbox"/> Interrupts Frequently | <input type="checkbox"/> Bed wetting/bowel control |

Does your child have any health problems? Yes No

If "Yes", please describe what they are: _____

Have any of other family members (parents, grandparents, aunts, uncles, siblings, cousins, etc.) experienced emotional problems? Yes No

If "Yes", who and what type of problem? _____

What would you like to accomplish from your child's treatment here? _____

Please list any specific questions you have for us: _____

Thank you for taking the time to complete this form. It helps us make the best use of our session time.