Aspen Psychological Services
640 3 Mile Rd, NW, Suite 101
Grand Rapids, MI 49544
616-785-8900 (office)
616-785-8949 (fax)

Therapist assigned: _____

ASPEN PSYCHOLOGICAL SERVICES
NEW PATIENT INFORMATION FORM – CHILD/ADOLESCENT

Date: ___ /___ /___

Client Name: _____
Last First MI

Sex: M or F Date of Birth: _____

Referred by: _____

Questionnaire completed by: Father Mother Both Other

FAMILY INFORMATION

Father: Biological, Step, Adoptive, Foster, Grandfather (circle)

Name: _____Age: _____ DOB: _____
Address: _____
City: _____State: _____ Zip Code: _____
Phone: _____ (home) ___ Ok to Call ___ Ok to leave message
_____ (cell) ___ Ok to Call ___ Ok to leave message
_____ (work) ___ Ok to Call ___ Ok to leave message
SSN: _____ Education: _____
Occupation: _____ Employer: _____ Yrs: _____
Religious Affiliation and involvement:_____

Mother: Biological, Step, Adoptive, Foster, Grandmother (circle)

Name: _____Age: _____ DOB: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ (home) ___ Ok to Call ___ Ok to leave message
_____ (cell) ___ Ok to Call ___ Ok to leave message
_____ (work) ___ Ok to Call ___ Ok to leave message
SSN: _____ Education: _____
Occupation: _____ Employer: _____ Yrs: _____
Religious Affiliation and Involvement: _____

Please list brothers and sisters (biological, half, step)

SIBLINGS	Age	DOB	EDUCATION	Living in Home
				Y N
				Y N
				Y N
				Y N
				Y N
				Y N

Please list any other people presently living in the family home.

_____

_____

PRESENTING PROBLEM

What is your reason for seeking consultation/counseling? _____

_____

_____

How long has this been a problem? _____

_____

MENTAL HEALTH HISTORY

Has your child had previous counseling? ___ Yes ___ No

Is there a history of emotional, physical, sexual abuse in your family? ___ Yes ___ No

If yes, please explain _____

_____

Date	Name of Counselor	Agency/Hospital	Reason for Termination	Inpatient	Outpatient

Is there any history of mental illness in your family of origin? (parents, grandparents, siblings)

_____

_____

Current Medications

Medication	Condition	Prescribed by	Start Date	Effectiveness/Side Effects

Previous Medications

Medication	Start Date	Stop Date	Prescribed By	Reason for Termination

Substance Use / Abuse History

	None	Past	Present	Frequency / Amount
Alcohol				
Drugs				
Nicotine				
Caffeine				

Has your child received treatment for any of the above? ___ Yes ___ No
If yes, when, for what substance and for how long? _____
_____
Is there a history of substance abuse in your family of origin? (parents, grandparents, siblings)
_____

MEDICAL HISTORY

Personal Physician _____ Last seen _____
Address _____
Date of last complete physical examination _____
Is your child experiencing any difficulty with sleeping? _____
Is your child experiencing any changes in appetite? _____

Please list significant illnesses, injuries, hospitalizations (including location).

_____

_____

Does your child have any allergies? Yes/No Please list/Describe.

_____

_____

_____

_____

Has your child ever had problems with hypersensitivity to medications or seizures/convulsions, including during infancy? If yes, please describe type, age of your child and medications used.

_____

_____

_____

_____

Please list and explain any recent or current health problems. _____

_____

_____

_____

_____

Is there a family history of:

		Yes/No	Relationship to Child
a.	Suicide	_____	_____
b.	Depression	_____	_____
c.	Other emotional problems	_____	_____
d.	Alcoholism	_____	_____
e.	Substance Use/Abuse	_____	_____

DEVELOPMENTAL HISTORY

Were there any complications with the pregnancy or delivery of this child?
Please explain._____

_____

_____

Did your child's development appear early, normal, or delayed (crawling, talking, walking, toilet training, etc)? Please explain. _____
_____
_____
_____

Please identify any history of physical, emotional, or sexual abuse experiences.
_____
_____
_____
_____

Please identify any hobbies or special interests of your child.
_____
_____
_____
_____

Describe your child's friendships, including number, ease of formation, duration.
_____
_____
_____
_____

Please list any employment history or regular home responsibilities for your child.
_____
_____
_____
_____

Please list any contacts your child has had with the police or the court system (include dates and results).
_____
_____
_____
_____

Please identify your child's strengths.
_____
_____
_____
_____

EDUCATION INFORMATION

What is the highest level of school your child has completed? _____

What was/is the last/current school attended? _____

Has your child experienced any of the following in school?

____ Learning problems ____ Discipline problems
____ Social problems ____ Emotional problems

Has there been any academic or psychological testing done at school or elsewhere?
___ Y ____ No, If yes, when/where_____
Result: _____

What have been your child's usual report card grades?_____

What are your child's most recent grades?_____

Describe any learning disabilities/difficulties for your child.
_____
_____
_____
_____

Describe any behavioral/discipline problems.
_____
_____
_____
_____

Describe your child's relationships with their teacher(s).
_____
_____
_____
_____

ADDITIONAL INFORMATION/COMMENTS

Check any of the following that applies to the child or adolescent at the present time.

___ Feeling depressed
___ Always tired
___ Poor appetite
___ Trouble sleeping
___ Loss of Weight
___ Weight gain
___ Lack of energy
___ Crying spells
___ Unable to have fun
___ Feelings easily hurt
___ Lacks confidence
___ Feeling grouchy
___ Feeling lonely
___ Lack of enjoyment in activities
___ Suicidal thoughts
___ Suicide attempt(s)
___ Self-harming behaviors
___ Feeling inferior
___ Unmotivated/Can't get going
___ Nightmares
___ Overly sensitive
___ Feeling unloved
___ Feelings of rejection or abandonment
___ Feelings of guilt
___ Feeling anxious
___ Fast heartbeat
___ Frequent sweating
___ Dizziness
___ Shaky hands
___ Stomach trouble
___ Feeling tense
___ Cold feet and hands
___ Always worried
___ Worried about health
___ Constipation
___ Muscle twitching
___ Nausea or vomiting
___ Headaches
___ Fainting spells
___ Feeling panicky
___ Unable to make decisions
___ Flashbacks
___ Painful memories
___ Separation anxiety
___ Substance abuse
___ Alcohol use
___ Smoking
___ Problems with siblings/peers
___ Problems with parents
___ Fighting and quarreling
___ Stealing
___ Lying
___ Sexual acting out behavior
___ Easily angered
___ Physical aggression
___ Feel like hurting someone
___ Feel like smashing things
___ Easily distracted
___ Hyperactivity
___ Poor concentration
___ Easily excited
___ Restless/fidgety
___ Learning disability
___ Speech/language problems
___ Stuttering
___ Poor social skills
___ Shy with people
___ Difficulty making/maintaining friendships
___ No one understands me
___ Poor physical health
___ Poor hygiene practices
___ Bedwetting
___ Tics
___ Can't handle money
___ Impulsive
___ Poor decision making