

CAROLINA PSYCHOLOGICAL ASSOCIATES, P.A.

5509-B West Friendly Avenue, Suite 106

Greensboro, NC 27410

Telephone: (336) 272-0855

Fax: (336) 272-9885

Today's Date: \_\_\_\_\_

Name of Child: \_\_\_\_\_

Name he/she is called: \_\_\_\_\_ Gender: \_\_\_\_\_ Age \_\_\_\_\_

Date of birth : \_\_\_\_\_ S.S. # \_\_\_\_\_

Parent Information, please check:

Single \_\_\_\_\_ Married \_\_\_\_\_ Partnered \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

If divorced, who has legal custody? \_\_\_\_\_

If custody, sole custody or joint custody? \_\_\_\_\_

Child lives with: Both parents \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Foster parents \_\_\_\_\_

**Father (Stepfather) Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
(City) (State) (Zip Code)

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ S.S.# : \_\_\_\_\_

Place of Employment: \_\_\_\_\_

**Mother (Stepmother) Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
(City) (State) (Zip Code)

Home Phone: \_\_\_\_\_ Business Phone \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ S.S.#: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

PERSON RESPONSIBLE FOR PAYMENT:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

**PER NORTH CAROLINA STATE LAW: The financially responsible person is the adult who signs the consent for services.**

**THE FINANCIALLY RESPONSIBLE ADULT IS THE PERSON WHO SIGNS THE CONSENT FOR SERVICES.**

Name of person referring you to me: \_\_\_\_\_

When did your child's problems/symptoms begin? \_\_\_\_\_

Please list the names, ages, and relationship to this child of those (other than parents) living in the home:

Name	Age	Relationship (brother, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list other family members no longer living at home:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any unusual health problems of child: \_\_\_\_\_  
\_\_\_\_\_

Is the child taking any prescribed medication? Yes \_\_\_\_\_ No

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

Does child have problems with vision? \_\_\_ hearing? \_\_\_ If so, explain: \_\_\_\_\_  
\_\_\_\_\_

Briefly describe your child's main problems. (Describe the problems, when they began, when they happen now, what you do to handle them, etc.): \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Please use back of page if additional space is needed)

Have you talked to other people (doctor, minister, etc.) or agencies (Social Services, public health, etc.) about this problem? Yes\_\_\_\_\_ No\_\_\_\_\_

School your child attends: \_\_\_\_\_

Grade:\_\_\_\_\_ Teacher:\_\_\_\_\_ If child has been seen by any of these specialists in school, please check: School Psychologist\_\_\_\_\_ Speech Therapist\_\_\_\_\_ Learning Disability Teacher

Is your child in any special classes at school? Yes\_\_\_\_\_ No\_\_\_\_\_ If so, what class(es) and how often?

Check those items which apply to your child:

#### DISCIPLINE

- \_\_\_\_\_ Will not do as he/she is told
- \_\_\_\_\_ Has temper tantrums

#### SOCIAL BEHAVIOR

- \_\_\_\_\_ Is excessively shy
- \_\_\_\_\_ Loses temper easily
- \_\_\_\_\_ Has been caught cheating or stealing
- \_\_\_\_\_ Tells lies
- \_\_\_\_\_ Cannot be quiet or sit still, even for short periods of time.
- \_\_\_\_\_ Is disruptive in school and at home

#### SUBSTANCE ABUSE

- \_\_\_\_\_ Uses illegal drugs
- \_\_\_\_\_ Uses alcohol or cigarettes without parental permission

#### MOOD AND SELF IMAGE

- \_\_\_\_\_ Is anxious and worries a lot
- \_\_\_\_\_ Has unusual fears - of what? \_\_\_\_\_
- \_\_\_\_\_ Cries easily
- \_\_\_\_\_ Has poor self-image, thinks of him/herself as dumb, ugly or unloved
- \_\_\_\_\_ Conceited, has overly high opinion of self, thinks he/she is better than others
- \_\_\_\_\_ Talks about suicide

#### HEALTH

- \_\_\_\_\_ Complains of frequent pains - where? \_\_\_\_\_
- \_\_\_\_\_ Frequently complains of being sick for no obvious reason
- \_\_\_\_\_ Problems with appetite: eats too little\_\_\_\_\_ or too much\_\_\_\_\_
- \_\_\_\_\_ Has difficulty sleeping
- \_\_\_\_\_ Wets or soils self