

CAROLINA PSYCHOLOGICAL ASSOCIATES, P.A.

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PATIENT INFORMATION

Today's Date: _____

Name of Child: _____

Name he/she is called: _____ Sex: _____ Age: _____

Date of Birth: _____ SS#: _____

Parent Information: Please Check:

Married _____ Separated _____ Divorced _____ Widowed _____

If divorced, who has legal custody? _____

Is custody sole custody or joint custody? _____

Child lives with: Both parents _____ Mother _____ Father _____ Foster parents _____

Father (Stepfather) Name: _____

Address: _____

(Box Number or Street)

(City)

(State)

(Zip)

Home Phone: _____ Business Phone: _____ Occupation: _____

SS#: _____ Place of Employment: _____

Mother (Stepmother) Name: _____

Address: _____

(Box Number or Street)

(City)

(State)

(Zip)

Home Phone: _____ Business Phone: _____ Occupation: _____

SS#: _____ 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