Carolina Psychological Associates
5509-B West Friendly Avenue
Suite 106
Greensboro, NC 27410-4249

Today's Date: _____

Name of Child: _____

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

Date of birth: _____ SS #: _____ Adopted: Yes/No

Parent Information Please Check:

Single _____ Married _____ Partnered _____ Separated _____ Divorced ____ Widowed ____

If divorced or separated, who has legal custody? _____

If custody, sole custody or joint custody? _____

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

Parent/Guardian: Mother___ Father ___ Stepmother ___ Stepfather ____ Guardian _____

Name: _____

Address: _____

_____ _____
(City) State Zip Code

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Occupation: _____ S.S. #(REQUIRED) _____

Place of Employment: _____

Co-Parent/Guardian: Mother__ Father __ Stepmother ___ Stepfather ___ Guardian _____

Name: _____

Address: _____

_____ _____
(City) State Zip Code

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Occupation: _____ S.S. #(REQUIRED) _____

Place of Employment: _____

Person responsible for payment: _____

Relationship to minor: _____

Address: _____

The financially responsible adult is the person who signs the consent for services.

Name of person/professional referring you to me: _____

When did your child's problems/symptoms begin? _____

Please list those (other than parents) living in the home:

Name	Age	Relationship (sister, uncle, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any unusual health problems the child has: _____

_____

Is the child taking any prescribed medications? Yes _____ No _____

If yes, list the medication(s) and prescriber here: _____

_____

_____

Does the child have problems with vision? ____ hearing? ____ If yes, explain: _____

_____

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: _____ Has your child been seen by any of these specialists

in school? (please check) School Psychologist ___ Speech Therapist ___ LD Teacher ____

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 with 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 apparent reason

_____ Problems with appetite: eats too little_____ or too much_____

_____ Has difficulty sleeping

_____ Wets or soils self