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www.rrpsychgroup.com

CHILD/ADOLESCENT INFORMATION FORM

Date:

PERSONAL DATA – please mark with an asterisk (*) your preferred mode of contact

Client Name:	**Home Phone**:
Address:	**Cell Phone**:
	Work Phone:
DOB & Age:	**Email Address**:
SSN:	**Contact Person & Relationship to Client**:
Referral Source:	**Emergency Contact Phone Number:**

PAYMENT - INSURANCE & BENEFIT INFORMATION (if applicable)

Insurance Company:	**Phone #**:
Insurance ID #:	**Group #**:
Subscriber Name:	**Client Relationship to Subscriber**:
Subscriber DOB:	**Person Responsible for Bill:**
Subsrciber Address (if different from above):	**Address of Person Responsible for Bill (if different from above):**
Co-pay/Co-Insurance:	**Deductible (Amount met?):**

CANCELLATION POLICY

A 24-hour advance notice is required for cancellation of your scheduled appointment.
A missed appointment fee will be charged at FULL OUT-OF-POCKET FEE to the credit card on file.

After 30 days, any unpaid balance will be charged to the credit card on file.
You will be refunded upon the receipt of insurance payments for outstanding dates of service.

CERTIFICATION AND AUTHORIZATION (if applicable)

I certify that the above information is correct. I authorize the release of any medical information necessary to process this claim.
I request that payments be made directly to Reynolds & Rubino Psychology Group, LLC on my behalf.
Therefore my signature will be on file to file with my insurance company.

Signature of Patient (or Parent): ______________________________________ **Date:** ____________________________

CHILD/ADOLESCENT INFORMATION FORM

Please bring photocopies of your child's recent school report cards, standardized test score results, and any educational, medical, or psychological reports.

Child's Name:	Date of Birth:	Age:	Sex:

Race/Ethnicity:

☐ American Indian/ Alaskan Native ☐ Asian ☐ Black/ African/American ☐ Hispanic/ Latino ☐ Hawaiian/ Pacific Islander ☐ White/ Caucasian ☐ Other: ______________

School:	Grade:
Legal Guardian(s):	Relation to Child:

Person Filling Out This Form:

☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Other: __________________

Biological Parents' Marital Status:

☐ Married ☐ Never married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Describe the problem that brings you here today.

Current Symptoms include (check all that apply):

- ☐ I have no problems or concern bringing me here
- ☐ Aggression, violence
- ☐ Anger problems
- ☐ Attention problems
- ☐ Career concerns, goals, and choices
- ☐ Parenting issues (your own child)
- ☐ Custody of Children
- ☐ Delusions (false ideas)/ Hallucinations
- ☐ Dependence
- ☐ Depression
- ☐ Divorce, separation
- ☐ Drug use
- ☐ Eating/appetite problems
- ☐ Fatigue/Low energy
- ☐ Fears, phobias
- ☐ Financial problems
- ☐ Grief
- ☐ Health, medical concerns
- ☐ interpersonal conflicts
- ☐ Irritability
- ☐ Legal matters problems
- ☐ Loneliness
- ☐ Memory problems
- ☐ Mood swings
- ☐ Nervousness, tension
- ☐ Obsessions/ compulsions
- ☐ Pain, chronic
- ☐ Panic or anxiety attacks
- ☐ Perfectionism
- ☐ Relationship problems
- ☐ School problems
- ☐ Self-esteem
- ☐ Sexual problems
- ☐ Shyness, oversensitivity to criticism
- ☐ Sleep problems
- ☐ Smoking and tobacco use
- ☐ Spiritual, religious, moral, ethical issues
- ☐ Stress
- ☐ Suicidal thoughts
- ☐ Temper problems
- ☐ Thought disorganization and confusion
- ☐ Withdrawal, isolating
- ☐ Work problems
- ☐ Other concerns or issues: ________________________
  ____
  ____

How long have these difficulties been present?

What are your **goals** for treatment?

MENTAL HEALTH AND MEDICAL HISTORY

Describe any stressors that might be affecting your child now (i.e. academics, death, divorce, trauma, conflict):

____

____

____

____

Has your child been diagnosed with any behavioral, educational, medical, neurological, or psychiatric disorder, such as Attention Deficit/Hyperactivity Disorder (ADHD), Learning Disorder (LD), Anxiety or Depression? If YES, please specify:

____

____

Mental Health History: *Has your child received a previous evaluation or intervention? YES NO*

Previous Mental Health Treatment or Evaluation:			
Date(s)	Therapist/Facility	Reason for seeking treatment/evaluation	Outcome/ Was treatment helpful?

PSYCHIATRIST (if applicable):	
Psychiatrist Address	
Psychiatrist Phone#	
Diagnosis:	
PEDIATRICIAN:	
Pediatrician Address	
Pediatrician Phone #	

CURRENT MEDICATIONS					
Medication	Dosage/ Times per Day	Reason for prescription	How long on medication?	Who Prescribed?	Is medication helpful?

When was your child's most recent medical exam? ____

Does your child have any vision, hearing (including ear infections), speech, or motor coordination problems? If YES, please explain the problem and treatment.

____

____

Please indicate any significant illnesses/conditions that your child has had and treatment for these conditions.

____

____

Has your child ever been taken to the Emergency Room or been admitted to the hospital? If YES, please list why and how old your child was at the time of the visit.

____

____

Does your child display any unusual sensitivities to BRIGHT LIGHT, LOUD SOUNDS, or TOUCH? YES NO

Does your child have any sleeping difficulties (i.e., trouble falling asleep, staying asleep, waking)? YES NO

Does your child have any unusual eating patterns or habits? YES NO

CHILD'S BIRTH AND DEVELOPMENTAL HISTORY

Were there any problems with the pregnancy or birth of your child? Did the biological mother use any tobacco, medication, street drugs, or alcohol while pregnant with this child? If yes, please describe.

____

____

Did your child have any developmental delays in early childhood (crawling, walking, talking, toileting, etc.)? If yes, please describe.

____

____

FAMILY & HOME INFORMATION

Place of birth: __________________ Where raised: __________________ Raised by who?: __________________________

Mother's Name: ___________________________ Age: _____ Education: ___________ Occupation: ___________________

Father's Name: ___________________________ Age: _____ Education: ___________ Occupation: ___________________

Stepfather (if applicable) ___________________ Age: _____ Education: ___________ Occupation: ___________________

Stepmother (if applicable) __________________ Age: _____ Education: ___________ Occupation: ___________________

If parents are separated/divorced, who has primary physical custody of the child? ________________________________

Age of child at separation? _________________

Describe the current custodial arrangement. ____

Adults, siblings and/or others living in the home:

Name	Age	Relationship (parent/brother/sister/etc.)	History of problems with behavior, learning, psychiatric (i.e., ADHD, depression, anxiety, substance abuse)?
What was your child's birth order: ________ out of ______			

Is there any other family history of mental health issues in the child's biological family (i.e., ADHD, learning problems, depression, anxiety, bipolar disorder, schizophrenia, substance abuse, etc.)? If YES, please describe:

____

____

EDUCATIONAL HISTORY

Early School Performance

Did you or any teachers have any concerns about your child's early school performance? Please describe:

____

____

Please describe your child's significant strengths and weaknesses in his/her academic performance.

____

____

Has your child changed schools for reasons other than normal academic progression? Has your child skipped or repeated any grades in school? If YES, when and for what reason?

____

____

Recent School Performance

Do you or any teachers have any concerns about your child's <u>recent</u> academic performance?

____

____

Has your child's school performance in (or attitude toward) school changed in the last two years? If YES, explain.

____

____

Does your child have any special needs or accommodations at school? Does your child receive any special services at school?

____

____

BEHAVIOR

Do you have any concerns regarding your child's behavior either at home, in public or at school? If YES, explain.

____

____

____

How do you handle discipline in your family? Do you feel these methods are successful in managing your child's behavior?

____

____

SOCIAL SKILLS

About how many close friends does your child have? ___ NONE ___ ONE ___ TWO OR THREE ___ FOUR OR MORE

Please describe any concerns you or others may have regarding your child's ability to get along with other children or your child's ability to interact with adults.

____

____

____

Please list your child's extracurricular activities or social organizations.

____

____

Other:

Is there any other information that you think may help us in understanding and working with your child?

My signature below indicates that I have voluntarily and accurately completed the Form. A photocopy of this agreement will be considered as valid as an original.

____

Client name Signature of Client Date