South Florida Psychological Associates, LLC

4121 SE 4th Avenue, Suite B
Plantation, FL 33316
(954) 909-7793

NEW CLIENT INFORMATION

Client Name : ____ Today's Date: _________________

Date of Birth: ___/____/_______ Age: ______ Gender: ______ Social Security # ____/____/_______

Address: ____

City: ____ State: __________ Zip Code: __________

Cell/Mobile Phone: ______________ Home Phone: _______________ Work Phone:_______________

Email: ____ Fax: _____________________

THE BEST WAY TO REACH ME IS (circle one): Cell/Mobile Home Work Email

IS IT OK TO LEAVE MESSAGES REGARDING APPOINTMENT TIMES, ETC? (circle one): YES NO

IS IT OK TO SEND TEXT MESSAGES TO YOUR CELL/MOBILE? (circle one): YES NO

IS IT OK TO SEND MAIL TO THE ABOVE ADDRESS? (circle one): YES NO

IS IT OK TO SEND EMAIL'S TO THE ABOVE EMAIL? (circle one): YES NO

List limitations in communicating with you: ____

Height: ________ Weight: ________ Hair Color: ________ Eye Color: _________ Handedness: ________

Current grade in school: _________ School: ___________________________ Teacher: ________________

Employed By: ______________________________ Occupation: __________________ City: ____________

How were you referred to this office? (circle): Self-Referred Doctor Family Friend Ad Internet Other

Name of internet site/ad/treatment facility/other: ____

Whom may I thank for referring you? : ____

Emergency Contact Person: ____ Phone: ___________________

Name of person who filled out this form: ____

South Florida Psychological Associates, LLC

4121 SE 4th Avenue, Suite B
Plantation, FL 33316
(954) 909-7793

CHILD FORM

Please fill out this form for your child as completely as possible. If your child is able to fill in certain information, please allow them to do so. It will help me in my work with them.

PRESENTING PROBLEM:

Please describe the main difficulty that has brought you to seek treatment at this time. Be as specific as you can.

____

____

CHILD'S MEDICAL CARE: (From whom or where does your child get medical care?)

Primary Care Doctor ______________________ Phone: ____________ Fax: ____________

Date of Last Visit: __________ Address: ________________________________

Medical Problems: ____

Surgeries (for what and when?): _______________________________________

Current medications prescribed by this provider: ___________________________

Describe reaction to medications: _____________________________________

List any allergies: ____

Other comments: ____

May we contact your primary doctor so that we can coordinate your treatment? (circle one): YES NO

Psychiatrist: ________________________ Phone: ____________ Fax: ____________

Date of Last Visit: __________ Address: ________________________________

Psychiatric Problems: ____

Current medications prescribed by this provider: ___________________________

Describe reaction to medications: _____________________________________

May we contact your psychiatrist so that we can coordinate your treatment? (circle one): YES NO

Has your child received previous psychological care? (circle one): YES NO

If YES, please indicate which type of treatment (circle): INPATIENT OUTPATIENT BOTH

When: __________________From Whom: ____________________________ For What: _________________________

When: __________________From Whom: ____________________________ For What: _________________________

When: __________________From Whom: ____________________________ For What: _________________________

Describe outcomes of previous treatment(s): ____

____

Other comments: ____

May we contact your previous psychological providers(s) for continuity of care? (circle one): YES NO

EDUCATION:

Academic Performance: ____

Behavior's in School: ____

What activities is your child involved in while at school? ____

How does your child interact with peers at school? ____

Has your child ever had to repeat a grade? (circle): YES NO If so, which grade(s)? ________________________

Has your child ever received special education services? (circle): YES NO If so, which grade(s)? ______________

If your child currently has an IEP, please explain: ____

____

If your child currently as a 504 Plan at school, please explain: ____

____

Additional Comments about School: ____

____

PRESENT RELATIONSHIPS:

Parents Marital Status (circle): MARRIED DIVORCED/SEPARATED WIDOWED SINGLE DATING OTHER ______

If in a relationship, for how long? __________________ Quality of Relationship: ____________________________

List all persons living at home other than child:

NAME	AGE	RELATIONSHIP TO CHILD

Father's Name: ____________________ Age: ________ Occupation: ____________________________________

Describe Father's Relationship with Child: ____

Mother's Name: ___________________ Age: ________ Occupation: ____________________________________

Describe Mother's Relationship with Child: ____

Step-Father's Name: _______________________ Age: _________ Occupation: _______________________________

Describe Step-Father Relationship with Child: ____

Step-Mother's Name: _____________________ Age: _________ Occupation: _______________________________

Describe Step-Mother's Relationship with Child: ____

How does your child get along with others in the home? ____

____

What are your child's favorite activities, sports, hobbies? ____

____

What are your child's responsibilities at home? ____

____

Does your child have any behavioral problems? ____

____

Describe how child is disciplined at home: ____

____

How does child respond to form(s) of discipline? ____

____

Any current or pending civil or criminal litigations, lawsuits or divorce/custody disputes? (circle one): YES NO

If YES, please explain: ____

____

Who has legal custody of this child? ____

PREGNANCY, BIRTH, AND EARLY DEVELOPMENT:

What kind of delivery during birth? (circle): VAGINAL C-SECTION BREECH

Note any complications during delivery: ____

Note any complications during pregnancy: ____

Prescribed medications taken during pregnancy: ____

Substance use during pregnancy (include cigarettes): _______________________________________

Note any post-delivery complications: ____

Eating patterns during infancy: ____

Sleeping patterns during infancy: ____

Temperament: ____

How were developmental milestones met? (circle one): EARLY ON-TIME LATE

If late, please provide additional information here: _______________________________________

____

Check any of the following that were present during the first few years of life:

_____ Did Not Enjoy Cuddling	_____ Frequent Head-Banging	_____ Mute
_____ Was Not Calmed by Being Held	______ Difficulty Nursing	_____ Loss of Speech/Babbling
_____ Difficult to Comfort	_____ Constantly into Everything	_____ Lack of Facial Expression
_____ Colic	_____ Lack of Eye Contact	_____ No Body Gestures
_____ Excessive Restlessness	_____ Unresponsive	_____ Lack of Interest/Enjoyment
_____ Excessive Irritability	_____ Poor Appetite	
_____ Diminished Sleep	_____ Delayed Language	

FAMILY MEDICAL HISTORY:

Describe any illness that runs in the family (cancer, epilepsy, thyroid, etc.): ___________________________________

____

____

FAMILY HISTORY OF PSYCHIATRIC ISSUES: (Check any that apply to your family history):

_____ ADD/ADHD	_____ Dementia	_____ Phobia	_____ Other ________
_____ Addiction	_____ Depression	_____ Physical Abuse	_____ Other _______
_____ Alcoholism	_____ Delusions	_____ Psychosis	_____ Other ________
_____ Alzheimer's	_____ Dissociation	_____ PTSD/ Trauma	_____ Other _______
_____ Anger Management	_____ Domestic Violence	_____ Perfectionism	
_____ Anorexia	_____ Emotional Eating	_____ Schizophrenia	
_____ Antisocial	_____ History of Neglect	_____ Self-Control	
_____ Anxiety	_____ Homicidal	_____ Sexual Abuse	
_____ Bereavement	_____ Major Mental Illness	_____ Self-Harm	
_____ Bipolar	_____ Over-Exercise	_____ Suicide	
_____ Bullying	_____ Obsessions	_____ Treatment (inpatient)	
_____ Bulimia	_____ Panic Attacks	_____ Treatment (outpatient)	
_____ Conduct Problems	_____ Personality Disorder		

Past or Present Drug/Alcohol Use and Abuse (treatments, AA/NA): ____

____

____

Past or Present History of Abuse or Neglect (physical, emotional, sexual): ____

____

____

Suicide Attempt(s) or Violent Behavior (describe: ages, reasons, circumstances, how, etc.): ___________________________

____

____

Friendships, Community, Religious or Spiritual Involvement (describe quality, frequency, etc.): ________________________

____

____

Strengths and Accomplishment (Please lists strengths, talents, skills, and accomplishments):

____

____

____

____

____

OTHER:

What other information about yourself do you think would be important for us to know?

____

____

____

____ ____________________

PRINT Client Name Date

____ ____________________

SIGNATURE of Client/Parent or Legal Guardian Date