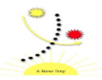

# New Day Psychology, LLC

## CLIENT INFORMATION FORM – CHILD/ADOLESCENT

Child's Full Name: ________________________________________ Today's Date: _________________________

Date of Birth: _______________________________ Age: ________________ Gender: ___________________________

Address:______________________________________________________________________________________________
(Street) (City) (State) (Zip code)

School: ______________________________________________________________ Grade: _____________________
(Name) (City)

Parent Mother/guardian Name: ______________________________ * **Date of Birth:**_______________________________

Address:______________________________________________________________________________________________
***If Different from Child's** (Street) (City) (State) (Zip code)

**I ____________________ agree that my child (name)_____________________ participates in therapy with Dr.**

**Name:________________Dor . ______________ Signature: ______________________ Date:____________ (365 days)**

**Disagree** ☐ **(reason)**_______________________________________________________________________________

Parent Father/guardian Name: _______________________________* **Date of Birth:** _______________________________

Address: _____________________________________________________________________________________________
*If Different from Child's (Street) (City) (State) (Zip code)

**I __________________ agree that my child (name) ______________________ participates in therapy with Dr. Dor .**

**Name:__________________________________ Signature: _______________________ Date: ___________ (365 days)**

**Disagree** ☐ **(reason)** ______________________________________________________________________________

Parent's marital status: _________________________________________________________________________________

Step-mother: ________________________________________ Step-father: ______________________________________

Current custody arrangement (if applicable):

______________________________________________________________________________________________________

______________________________________________________________________________________________________

**Please list other Parents/Step parents/Guardians/other important family members (not siblings):**

| ***Name*** | ***Relationship*** | ***Age*** | ***History of illness (physical/mental)*** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |



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**I may be contacted by:**

**Text:** Yes ☐ No ☐ Mother's Cell phone: ____________________ Father's Cell phone: ________________

**Email:** Yes ☐ No ☐ Mother/Guard. Email: _____________________ Father/Guard. Email: _______________

**Home:** Yes ☐ No ☐ May I leave a message on the answering machine? Yes ☐ No ☐

**If Different:**

Mother Home phone: ___________________________ Father Home phone: ________________________________

**Work:** Yes ☐ No ☐ **Work:** Yes ☐ No ☐

Work phone: ____________________________________ Work phone: ______________________________________

**Others** - Leave a message/call ____________________ Relationship _______________ at this number ____________

Please list any restrictions: ____________________________________________________________________

**Whom may I contact in case of an emergency?**

Name: ______________________________________ Relationship:_________________________________________

Phone: ______________________________________ Alternate phone: ____________________________________

**PLEASE COMPLETE THE FOLLOWING:**

In the space below, please briefly describe:

**The Reason(S) For Seeking Services for Your Child:**

_______________________________________________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

**When did this Issue Begin:** _______________________________________________________________________

**Has Your Child Ever had Previous Counseling or Psychotherapy?** Yes ☐ No ☐

**If "Yes," By Whom** ______________________________________________________________________________

**How long Ago and for how long**: ___________________________________________________________________

**Was it successful?** _____________________________________________________________________________

**Reason termination:** ____________________________________________________________________________

**FAMILY INFORMATION:**

Please list siblings (full/half/step) siblings in order of age:

| Name | Relationship | Age | History of illness (physical/mental/alcohol/drugs) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |



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**Other People Living In the Home:** ______________________________

Primary language spoken in the home: ____________________ Secondary: ______________

Non-residential adults involved with your child (e.g., nanny/ babysitter): ______________________

______________________________________________________________

## DEVELOPMENTAL/MEDICAL INFORMATION:

**Around what age did your child achieve these milestones? You can also write: Normal/ Delayed**

Crawled ____________ Walked ____________ Said first words ____________ Toilet trained ________

Any learning difficulties? Yes ☐ No ☐ (Describe) ______________________________

Has your child ever received services from a speech pathologist? Yes ☐ No ☐

Has your child ever received services from a physical therapist? Yes ☐ No ☐

Has your child ever received services from an occupational therapist? Yes ☐ No ☐

Does your child have sensory issues? Yes ☐ No ☐ *If yes:* Taste ☐ Noise☐ Cloths labels/seams ☐ other________

Has your child ever been evaluated for a special education or Section **504 plan**? Yes ☐ No ☐

Does your child have a current **IEP**? Yes ☐ No ☐ Primary Issue: __________ Secondary ____________

**Describe Any Major Illnesses, Injuries, Or Surgeries?**

| Illness | Hospitalized *(yes/no)* | Date | Lasting Effects if any? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Has your child ever had a concussion or serious head trauma?** Yes ☐ No ☐

**Has your child ever had a seizure?** Yes ☐ No ☐

## Current Medications:

| Medication name | Dosage | Medication name | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Name of Physician Psychiatrist**: ______________________________ **Phone**: ______________

**Address:** ______________________________________________________

**Are You Giving Me Permission to Communicate With the Physician/ Psychiatrist:** Yes ☐ No ☐

**Have you ever been psychiatrically hospitalized?** Yes ☐ No ☐



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**List Hospitalizations:**

| Hospital | Month/Year | Length of stay | Reason for hospitalization |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Is The Child Currently Saying She/He Wants Die? Yes ☐ No ☐

If Yes, Does He/ She Shared a Plan Yes ☐ No ☐

If Yes: Details ____________________________________________

Have Your Child Ever Made A Suicide Attempt/Gesture? Yes ☐ No ☐

Details: ____________________________________________

Family/Current Physician ______________________________ Phone:__________________

Special Diet? ____________________________________________

If - What Allergies Does the Child Have? ______________________________



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**Please Use the Scale Below to Indicate Your Child's Current Level of Distress with the Following Items:**

| Level of Distress (items) | Concern | Mild | Moderate | Urgent |
|---|---|---|---|---|
| Academic problems | 0 | 1 | 2 | 3 |
| Aggressive behavior | 0 | 1 | 2 | 3 |
| Self-Harm | 0 | 1 | 2 | 3 |
| Anxiety/fears/worries | 0 | 1 | 2 | 3 |
| Attention/concentration difficulties | 0 | 1 | 2 | 3 |
| Bedwetting | 0 | 1 | 2 | 3 |
| Behavior problems | 0 | 1 | 2 | 3 |
| Change in family constellation (e.g. divorce or remarriage) | 0 | 1 | 2 | 3 |
| Depression | 0 | 1 | 2 | 3 |
| Eating problems | 0 | 1 | 2 | 3 |
| Feelings over a recent loss/death | 0 | 1 | 2 | 3 |
| Losing contact with reality | 0 | 1 | 2 | 3 |
| Relationship with parent/s | 0 | 1 | 2 | 3 |
| Relationship with sibling/s | 0 | 1 | 2 | 3 |
| Relationship with peers | 0 | 1 | 2 | 3 |
| Problems with alcohol | 0 | 1 | 2 | 3 |
| Problems with drugs/ meds/substances | 0 | 1 | 2 | 3 |
| Sexual behaviors | 0 | 1 | 2 | 3 |
| Sleep problems | 0 | 1 | 2 | 3 |
| Suicidal feelings/behaviors | 0 | 1 | 2 | 3 |
| Trauma/Physical or sexual abuse | 0 | 1 | 2 | 3 |

**Other (not listed above):** ______________________________________________

______________________________________________

**Childs' Strengths:** ______________________________________________

______________________________________________

______________________________________________

______________________________________________

**Please list hobbies, sports, recreational, TV, or other activities; any special skills or talents:**

______________________________________________

______________________________________________

______________________________________________

______________________________________________



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***If Appropriate and Possible Please Let your Child Fill the Next 2 Sections:**

**Which Best Describes You?** (Please Fill All Following Statements).

## GAD-7

| Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✓" to indicate your answer")* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | 2 | 3 |
| 5. Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |

**Total Score** _____ = **Column totals:** ________ + _______ + _______ + _________

**If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

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## Which Best Describes You? (Please Fill All Following Statements).

## PHQ-9

| Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer")* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things………………. | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless……………….. | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much………………………………………………………… | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy……………………. | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating………………………………. | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down………………….. | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television……………………….. | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving .around a lot more than usual……………………………………………………………….. | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way……………………………………….. | 0 | 1 | 2 | 3 |

**Total Score _____ =** **Column totals:** ________ + _______ + _______ + ________

***If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

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