Lisa Gabardi, Ph.D., LLC

Licensed Psychologist

Client Information Sheet - Child/Adolescent

Client Name _____ Date of Birth _____
Street Address _____
City, State _____ Zip _____
Home Phone _____ School _____
Grade _____

Parent(s) with whom Client is living:

Name _____ Name _____
Date of Birth _____ Date of Birth _____
Social Security # _____ Social Security # _____
Driver's License # _____ State _____ Driver's License # _____ State _____
Employer _____ Employer _____
Work Phone_____ Work Phone_____
Job Title _____ Job Title _____
Marital Status _____ Marital Status _____

Person to be billed (if different from above):

Name _____ Date of Birth _____
Address _____
City, State, Zip _____
Relationship to client _____
Home Phone _____ Work phone _____
Social Security # _____Driver's License # _____ State _____
Employer _____
Job Title _____ Marital Status _____

Others in house	Relationship	Age	Occupation or Grade

Who referred you to this office? _____
Briefly describe the problems that brought you in today. _____
_____
_____
_____
_____
_____
_____
_____
_____

Have you previously received treatment from a mental health professional? ☐ yes ☐ no
If so, name:_____ Approx dates of treatment _____
Reason for previous mental health treatment?_____
_____
_____
How helpful was the previous treatment? _____
_____

Has your child mentioned suicide? ☐ yes ☐ no
Has your child threatened suicide? ☐ yes ☐ no
Has your child intentionally hurt him/herself? ☐ yes ☐ no
Has your child threatened to kill others? ☐ yes ☐ no
Has your child seriously hurt others? ☐ yes ☐ no
Has your child ever run away? ☐ yes ☐ no
Is your adolescent currently involved in a serious romantic relationship? ☐ yes ☐ no
For all questions marked yes, please provide details:

_____
_____
_____
_____
_____
_____
_____
_____

Check any symptoms your child has been having:

Difficulty sleeping		Lack of energy	
Toileting problems		Excessive energy	
Change in eating habits		Behavior problems at school	
Problems getting along with family		Trouble with the law	
Problems with friends		Truancy/stealing	
Doesn't enjoy usual activities		Irritability	
Trouble doing school work		Isolation/withdrawal	
Anxious		Feelings of guilt	
Low self-esteem		Tobacco use	
Perfectionistic		Drug/alcohol use	
Worries		Sudden feelings of panic	
Fears		Nightmares/sleep disturbances	
Frequent headaches, stomaches		Vindictive or spiteful	
Anger outbursts		Intentionally hurts animals	
Oppositional		Forgetful	
Vandalism/destruction of property		Bizarre or unusual behavior	
Firesetting		Pregnancy/sexual activity	

Please describe any other symptoms you are concerned about:
_____
_____
_____

Please describe your child's:
Strengths _____
_____
_____
Weaknesses _____
_____
_____

Developmental History:
Describe any problems in pregnancy and delivery:_____
_____
Were there any delays in achieving developmental milestones? If yes, describe:_____
_____
During the first 5 years, describe any concerns you had regarding your child's:
physical development: _____
language development: _____
intellectual development: _____
Emotional/behavioral development: _____
_____
Social development:_____
_____

Educational History:
Is your child currently receiving special education services? ☐ yes ☐ no
Are you concerned that your child may have a learning disability? ☐ yes ☐ no
Starting with preschool, please note how your child did academically and behaviorally in each grade:
Grade School Performance
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

How is your child doing this year, academically and behaviorally?

_____

_____

If your child is having problems at school, please complete one of the enclosed releases of information so that I may speak with your child's teacher or counselor.

Family History:

Has anyone else in the family ever had any psychological/psychiatric problems? Have there been any separations or divorces? Has anything happened to another family member that has affected this child? Please Explain.

_____

_____

_____

_____

_____

_____

Please describe the forms of discipline you use with your child.

_____

_____

_____

Who in the family has the best relationship with your child?_____

The worst?_____

For each family member who consumes alcohol, please list the type and amount of alcoholic beverages consumed in a typical week:

Name type of Alcohol (beer, wine, cocktail) Amount per typical week

_____

_____

_____

Is there any family history of alcohol/drug problems? ☐ yes ☐ no

Is there any family history of abuse or neglect? ☐ yes ☐ no

Medical History:

Physician _____ Approx date of last visit _____

Current medical problems? _____

Current Medications?_____

Please describe any previous hospitalizations or serious illnesses your child has experienced, including dates.

_____

_____

_____

Does your child have any allergies or negative reactions to medications? Please describe.

_____

_____

Please complete a release of information so that I may communicate with your child's physician.

Goals:
Please describe what you hope will occur as a result of our sessions together:
_____
_____
_____
_____

Alternative Communication Channels (Please circle which applies)
Please direct Postal Mail to my home address previously listed Yes No
If No, Please mail me at the following address: _____
_____
I give permission to be called at (Home) (Work) (Cell) _____
You may leave a message at (Home) (Work) (Cell) _____
Restrictions on messages and/or Special Instructions regarding contacting you: _____
_____

Emergency Contact
Name of Person to contact in case of emergency: _____
Address: _____
Phone: _____
Relationship to client: _____

Insurance Information:
❑ Please copy my insurance card. (Skip this section).
Name of Policy Holder _____ Relationship _____
Insurance Company _____
Billing Address _____
_____
City, State, Zip _____ Phone number _____
Policy # _____ Group # _____

_____ _____
Signature of Client or Personal Representative Date

_____ _____
Printed Name of Client or Personal Representative Relationship to Client

Alternative Communication Channels _____*Accepted*
_____*Refused* Reason(s): _____
_____

_____ _____
Signature-Dr. Gabardi, Privacy Officer Date