Christine Hall PsyD

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Patient Information for Children/Adolescents

Please complete, sign and date on last page

Patient Last name:	First name:	Middle:
Date of birth:	Age:	Male/Female:
Patients address:		

Date:_____Responsible Party:_____

Mothersname:_____ SS#_____

DOB:_____ Age:____Marital Status:_____

Physical Address:_____

Billing Address:_____

Home Phone:_____Work Phone: _____

Cell Phone:_____Preferred Contact Number:_____

May we leave messages at this number? Y/N

Employer:_____Occupation:_____

Employment address:_____

Fathers name:_____ SS#_____

DOB:_____ Age:____Marital Status:_____

Physical Address:_____

Billing Address:_____

Home Phone:_____Work Phone: _____

Cell Phone:_____Preferred Contact Number:_____

May we leave messages at this number? Y/N

Employer:_____Occupation:_____

Employment address:_____

<u>Emergency Contact other than Parents:</u>

Name:_____Relationship to pt:_____

Home phone:_____work:_____Cell:_____

Referred by:

_____

Work /school History:

Do you presently work? Y/N Full or Part time?:_____

Are you: A Student Y/N

If you are a student, where do you attend school?_____

What are you studying?_____

What are your grades?_____Classes you do best in? _____

Do you have any difficulties in school? Y/N If yes, please describe:

_____

_____

_____

_____

Medical History:

Do you have any major medical illnesses, previous hospitalizations, or accidents? Please list:

_____

_____

_____

_____

Have you had any previous psychiatric hospitalizations? Y/N

If yes, where/when?

_____

_____

_____

_____

Have you participated in therapy before? If so, when?

_____

Briefly describe the challenges addressed at that time.

_____

What prescription medications do you regularly take?

_____

_____

_____

_____

What recreational substances do you use, if any, including Alcohol and tobacco? (Include Past usage and Frequency)

_____Present/Past____How often? _____

_____Present/Past____How often? _____

_____Present/Past____How often? _____

_____Present/Past____How often? _____

Do you or others consider any of your substance use to be a problem? Y/N

If Yes, please describe_____

Are you having difficulty sleeping? Y/N If yes, describe:

_____

_____

Please describe your exercise habits, including type, frequency, and duration of each workout:

_____

_____

Are you having difficulty with your appetite or eating habits? Y/N If yes, describe:

_____

_____

Binging Restricting Eating more Eating Less Significant weight change

What do you enjoy doing in your free time?

_____

_____

Family Background Questionnaire

Please check any issues that apply to your family:

	Self	Mother	Father	Sibling
Alcohol Abuse				
Drug Abuse				
Depression				
Anxiety				
PTSD				
Bipolar Disorder				
Schizophrenia				
ADHD				
Learning Difficulties				
Attempted/Completed Suicide				
Psychiatric Hospitalizatio				
Legal Problems				
Financial Problems				
Verbal Abuse				
Physical Abuse				
Sexual Abuse				
Weight Issues				
Anorexia				
Bulimia				
Other				

Please list family members, ages, occupations, and state if they are biological/step/adopted. Also please state where they current live. If a family member is deceased, please list them as well when they passed.

_____

_____

_____

_____

_____

_____

Are your parents: married Divorced Remarried

If they have divorced and remarried, please indicate number of times they have been divorced and remarried:_____

Please use the space below to indicate the nature of your current challenges, including duration and how they impact your life/functioning, and why you are presenting for therapy:

HIPAA ACT AND NOTICE OF PRIVACY PRACTICES

I HAVE READ AND UNDERSTAND THE HIPAA PRIVACY FORM AND KNOW THAT THE POLICIES AND FORM IS AVAILABLE ON Dr. HALL'S WEBSITE FOR DOWNLOADING TO MY RECORDS.

Patient/Guardian/Parent Date