352 Seventh Avenue, Suite 306 New York, NY 10001
212-337-9990 (o) 212-337-9914 (f)
www.hartsteinpsychological.com

PATIENT INFORMATION (CHILD/ADOLESCENT): DATE: _____

Child's Name: _____

Parent's Name: _____ Parent's Name: _____

Legal Guardian's Name (if applicable): _____

Date of Birth: _____ Age: _____

Address: _____

Contact Information:	May we contact you at this number/address? (Y/N)	Any restrictions?
Home: _____	_____	_____
Cell (Parent 1) _____	_____	_____
Cell (Parent 2): _____	_____	_____
Cell (child) _____		
Work (Parent 1): _____	_____	_____
Work (Parent 2): _____	_____	_____
Additional numbers: _____	_____	_____

Email addresses, include child's: _____

_____

_____

School: _____ School Phone: _____

School contact person's name: _____ Relationship: _____

Name:_____

Grade: _____ If special education, please specify reasons why: _____

_____

Primary Care Physician: _____ Phone: _____

Who referred you? _____ Phone: _____

PRESENTING PROBLEM:

REASON FOR REFERRAL: Please describe why you are seeking services at this time.

_____
_____
_____
_____
_____
_____

When did these problems begin?

_____
_____

Does anything seem to make the problem better or worse? Y/N If yes, please explain:

_____
_____
_____
_____

Child's strengths:

_____
_____

CURRENT SYMPTOMS:

Please check off which problems/symptoms are apply to your child/adolescent within the past month:

- ☐ Sad/depressed mood
- ☐ Withdrawn
- ☐ Panic attacks
- ☐ Decreased appetite
- ☐ Early morning waking
- ☐ Excessive weight loss
- ☐ Poor attention/concentration
- ☐ Poor academic performance
- ☐ Oppositional/defiant
- ☐ Drug use
- ☐ Inappropriate sexual behavior
- ☐ Poor peer relationships
- ☐ Suicidal thoughts
- ☐ Anxious/tense
- ☐ Fatigue
- ☐ Angry outbursts
- ☐ Increased appetite
- ☐ Nightmares
- ☐ Purging
- ☐ Hyperactivity
- ☐ Truancy
- ☐ Stealing
- ☐ Alcohol use
- ☐ Physical aggression/fighting: _____
- ☐ Poor family relationships
- ☐ Suicide attempt
- ☐ Nonsuicidal self-injurious behavior, without intent to die (e.g. self-cutting, burning)

Name:_____

TRAUMA HISTORY:

Has there been any history of trauma in your child's life? Trauma can include, but is not limited to: physical or sexual abuse, accidents, or serious injury. Y/N If yes, please explain:

_____
_____
_____

FAMILY INFORMATION:

Please list family members below:

Name Age/Sex Relationship to Child Live in home? If not, where?

_____
_____
_____
_____
_____
_____

Please list other important family members who do not reside with the child (siblings, grandparents, etc.):

Name: Relationship to Child: Age:

_____
_____
_____
_____

Parent 1's occupation: _____

Parent 2's occupation: _____

Child's parents are: (please circle)

Married/domestic partners Divorced Separated Never married

Please specify custody arrangements and/or what individuals have legal guardianship over the child:

_____
_____

Have there been any deaths of/separations from family members or friends with whom the child was close or had frequent contact? Y/N If yes, please explain (include dates, relationship to child):

_____
_____
_____
_____

Name:_____

Is there a family history of psychiatric illness and/or learning difficulties? Y/N If yes, please specify what family member is affected and with what type of issue.

_____
_____
_____
_____
_____

Are there are any significant family conflicts that impact the child? Y/N If yes, please explain:

_____
_____

Who does most of the disciplining of the child and what methods are utilized?

_____
_____
_____
_____

Has ACS (Administration for Children's Services), or any other social service agency, ever been involved with your family? Y/N If yes, please explain why and when. If ACS is still involved, please provide the caseworker's contact information. _____

_____
_____

What is the race/ethnicity of the following members of the family?

Child: _____
Parent 1: _____
Parent 2: _____

Please list any religious, cultural or social issues that may impact treatment:

_____
_____

SOCIAL HISTORY

How does your child spend his/her free time?

_____
_____

Does your child have any difficulty making/keeping friends? Y/N If yes, please explain:

_____
_____

Does your child have a history of arrests/legal involvement? Y/N If yes, please explain:

_____
_____

EDUCATIONAL HISTORY

Has your child repeated a grade? Y/N If yes, please explain:_____

_____

Name:_____

Child's grades are: ____ Average _____ Below Average _____ Above average

Has there been a recent decline in grades? Y/N If yes, please explain: _____
_____

Does your child have any particularly difficult subjects? _____

Does your child have a history of receiving services in school (speech and language, occupational or physical therapy, tutoring, counseling, other)? Y/N If yes, please explain.
_____
_____

Has your child ever received a psychological evaluation? Y/N If yes, please explain when, where and the contact information of the evaluator. Also, please provide Hartstein Psychological Services with a copy of the most recent testing report.
_____
_____

Are there any problem behaviors reported in school (attention, interruptions, social skills issues, etc.)? Y/N If yes, please explain:
_____
_____

MEDICAL HISTORY

Pregnancy/Delivery/Developmental History:

Please list any complications the child's mother had during pregnancy:
_____
_____
_____

Complications during delivery:
_____
_____
_____

Child was born (please circle):
On time Pre-term by #_____days Post term by #_____days

If your child was adopted, from where was he/she adopted? _____

At what age (approximately) was your child adopted? _____

At what age (approximately) did your child achieve these developmental milestones?

Crawling:_____ Walking:_____ Toileting:_____

Talking (single words):_____ (sentences): _____

Name:_____

Does your child have a history of difficulty separating from you? Y/N If yes, please explain:
_____
_____

Please describe any other important information/concerns regarding your child's development:
_____
_____
_____

Medical Issues:

Please list/describe any medical issues your child has:
_____
_____
_____

Do you have any concerns about your child's nutrition/appetite and/or sleep? Y/N If yes, explain:
_____
_____
_____

Hospitalizations/Surgeries:
Dates Reason for Hospitalization/Surgery
_____
_____
_____

Current Medications/Reasons for use:
_____ _____
_____ _____
_____ _____

PSYCHOSOCIAL TREATMENT HISTORY

Has your child ever had psychological/psychiatric treatment of any kind? Y/N

If yes, please list the treatments your child has had (i.e.: Individual therapy, Family therapy, Group therapy, Psychopharmacology, Residential Treatment Center, Therapeutic Boarding School).

--Be sure to include: dates of treatment, previous provider's name and contact information, and reason for termination of treatment.

_____
_____
_____
_____
_____

Was there anything you found particularly effective or ineffective in your child's past treatment?
_____
_____
_____

Name:_____

Psychiatric Hospitalizations (Please include dates, length of stay, and reason for hospitalization):

_____
_____
_____

Psychiatric Medications (Please indicate what medication and, if discontinued, reasons for change or stoppage of medication):

_____
_____
_____

If your child is currently on psychotropic medication, please provide the name and phone number of the prescribing doctor:

_____
_____

ADDITIONAL INFORMATION

Please use this space to describe any other issues, questions or concerns that you have about your child/adolescent.

_____

_____

_____

_____

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