Betsy Rubel, PhD
Licensed Clinical Psychologist

The following is considered confidential and privileged information. Please answer all questions as well as you can.

Child's Name Birth Date Age

Parent Name Cell phone

Email

Parent Name Cell phone

Email

Parents are Marital Status

Home Address Home Phone

Pediatrician

Address Phone

Referred by

Person filling out this form Relationship to child

REFERRAL INFORMATION

What are the main problems or concerns that prompted your interest in psychotherapy?

Has your child ever had contact with any psychologist, psychiatrist, counselor, or social services before? Please list names of providers and dates of any previous treatment.

At what age was your child's problem first noted? By whom?

Have you consulted with anyone else for current problems?

Has your child ever had psychological testing at school or other setting? If yes, please indicate where and with whom the testing took place. **Please bring copies of previous test results/reports to the next appointment.**

My child's strengths are:

My child's weaknesses are:

CHILD'S DEVELOPMENTAL HISTORY

Age of mother at delivery Birth weight Vaginal or cesarean

Any known health problems of mother during pregnancy

Which medications, if any, did mother take during pregnancy?

Baby was born full term premature (weeks gestation)

Describe any difficulties during delivery

Describe any medical problems noted at birth or during infancy

Describe any concerns about developmental milestones

How active was the baby?

CHILD'S HEALTH HISTORY

Has your child had: (Please check all the following that apply and provide any relevant details)

Hospitalizations

Surgery

Trauma (e.g. fractures, serious accidents)

Head injury

Seizures/ convulsions / fits

Headaches or migraines

Meningitis

Serious illness/ infections/ high fevers

Asthma

Allergies

Medication allergies

Ear infections How many?

Hearing / vision problems

Toileting problems, bed wetting

Temper tantrums/ aggressive behavior

Unusual behavior

Sleep problems nightmares night terrors snoring trouble falling asleep

trouble staying asleep other

Other problems

Does your child eat more sugary / fatty foods than you would like? yes no

Is your child overweight, per pediatric guidelines? yes no

Is your child underweight, per pediatric guidelines? yes no

Is your child trying to diet or restrict what s/he eats? yes no

Does your child exhibit any peculiar eating patterns (eg eat non-food)? yes no

Any other eating or feeding problems or concerns?

Please list any current medications your child is taking, including the dosage

FAMILY HISTORY

Who is living in the home?

Name	Age	Health Problems
Name	Age	Health Problems
Name	Age	Health Problems

Name Age Health Problems

Name Age Health Problems

Occupation

Employer

Work address Work Phone

Occupation

Employer

Work address Work Phone

Please describe the degree of marital conflict

Please describe the major areas of marital conflict

Please describe the degree of conflict between child and parents

Please describe the degree of conflict between the children

Do parents agree on how to discipline the child? Please describe the areas of disagreement.

Who disciplines and how?

How does your child respond to discipline?

Has your child been exposed to any trauma recently or in the past?

Please check all of the following problems for which any immediate relatives (e.g. grandparents, brothers, sisters, aunts, uncles) have been diagnosed and/or treated

- Inherited / genetic conditions
- Birth defects
- Cerebral palsy / neuromuscular disorders
- Slow or retarded development
- Learning disabilities / dyslexia
- Neurologic condition
- Hearing / vision problems
- Thyroid or other hormone disorders
- Cancer
- Hyperactivity / ADHD
- Chronic headache or migraines
- Alcoholism or drug abuse
- Anxiety or chronic worry
- Panic attacks or phobias
- Motor tics or Tourette's syndrome

Depression

Bipolar or manic depressive illness

Schizophrenia, schizoaffective disorder, or chronic mental illness

Eating disorders (anorexia nervosa, bulimia nervosa, binge eating)

Autism, Asperger's syndrome, non-verbal learning disorder

Slow or delayed development

Hair pulling, nail biting, skin picking

Other emotional / behavioral problems

SOCIAL HISTORY

Does your child get along better with children older younger same age

Please describe your child's "social style"

At what age level do you believe your child is functioning socially?

How does your child perform athletically?

Does your child have and keep friends? Please explain any difficulties.

How often does your child have playdates? Does s/he express interest in playdates?

What are your child's favorite activities and pasttimes?

Please describe your child's temperament and personality (e.g. shy, immature, defiant, stubborn, impulsive, active, etc).

EDUCATIONAL HISTORY

Current school name Grade:

School address

Telephone Teacher's name

Any grades repeated? Any grades skipped? Special Ed?

Are there any current school problems in the following areas?

Reading Writing Spelling Math Social

Attention Compliance Mood Anxiety

If yes, then please explain:

Child's name

Parent's name

Parent's name

DOB Age Grade

School

Medication Dose

Medication Dose

Medication Dose