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Initial Session for a Child/Adolescent

Child's Name:______________________________ Gender:M / F Age:________

School:___________________________ Grade:______ Date of Birth:___________

Address:____

City:___________________ State:_____ Zip:________ Home Phone:_______________
May I send information to this address? Y / N May I call/leave messages at this number? Y / N
Person accompanying child:________________________ Relationship:______________

Circle who child lives with:
Both parents Mother Father Mother/Stepfather Father/Stepmother Other

Mother's Name:___________________

Address:_________________________

____

Home Phone:______________________

E-mail:__________________________
May I add you to my mailing list? Y / N
Cell Phone:______________________
May I call/leave messages at the above numbers? Y / N
Employer:________________________

Work Phone:______________________
May I call/leave messages at this number? Y / N
Spouse's Name:___________________

Father's Name:___________________

Address:_________________________

____

Home Phone:______________________

E-mail:__________________________
May I add you to my mailing list? Y / N
Cell Phone:______________________
May I call/leave messages at the above numbers? Y / N
Employer:________________________

Work Phone:______________________
May I call/leave messages at this number? Y / N
Spouse's Name:___________________

Who referred you to Dr. Hunnicutt?____________________________________
May Dr. Hunnicutt communicate with your referral source to let them know you have followed up on the recommendation for services? If so, please sign below.

____ ___________
Client or Parent/Guardian Signature Date

____ ___________
Angela Hunnicutt, Ph.D., HSPP Date

Please list the reason(s) you are bringing your child to see me at this time_____________
____
____

Has your child had any previous therapy? Y / N
If yes, please list providers and dates of treatment_______________________________
____

Child's Physician:_____________________________ Date of last visit:_____________
Please list any significant health problems/allergies your child has__________________
____
____
Please list any medications, with dosages, your child is taking_____________________
____
____

Last tobacco use and frequency____
Last illegal drug use and frequency____
Last alcohol use and frequency____

Circle any of the following that your child experiences at least once per week:

Poor appetite	Headaches	Difficulty paying attention
Overeating	Stomachaches	Not seeming to listen
Difficulty falling asleep	Sore muscles	Being easily distracted
Wanting to sleep a lot	Difficulty breathing	Losing things
Fatigue	Heart racing	Failing to finish tasks
Difficulty concentrating	Dry mouth	Making careless mistakes
Forgetting things	Tightness in jaw	Being disorganized
Difficulty making decisions	Teeth grinding	Avoiding tasks
Sadness	Shakiness	Being fidgety
Loss of interest in things	Chest tightness or pain	Restlessness
Crying easily	Blushing	Difficulty staying seated
Feeling worthless	Sweaty palms	Difficulty staying quiet
Easily annoyed/irritated	Difficulty staying asleep	Continuously on the go
Anger outbursts	Dizziness/faintness	Talkative
Feelings of guilt	Worrying/stewing	Being impatient
Hopelessness	Feeling fearful	Interrupting
Thoughts of death	Feeling tense or nervous	Racing thoughts
Thoughts of harm to self	Feelings of guilt	Obsessive thoughts
Thoughts of harm to others	Bad dreams	

Anything else I should know about your child (e.g. personality traits, religious affiliation, major life events)?____
____