LIMITLESS
PEDIATRIC THERAPY

NEW COUNSELING PEDIATRIC PATIENT QUESTIONNAIRE

PATIENT INFORMATION

FULL NAME: _____

SEX: Male Female BIRTHDATE _____ AGE _____

LEGAL GUARDIANS NAME(S) _____

CELL PHONE (MOM) _____ (DAD) _____

PRIMARY EMAIL ADDRESS: _____

PATIENTS PRIMARY ADDRESS: _____

PHONE NUMBER _____ RELATIONSHIP TO PATIENT _____

CAREGIVERS NAME: _____ PHONE: _____

How did you hear about us?

☐ Website/Search ☐ Doctor:_____ ☐ Friend:_____ ☐ Other: _____

BIRTH HISTORY:

Was child born full term? ☐ YES ☐ NO If not, how many weeks? _____

Were there any complications at birth?

_____

_____

Did the child spend any time in the NICU? ☐ YES ☐ NO If so, how long? _____

Did the child require oxygen? ☐ YES ☐ NO Length of hospital stay: _____

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MEDICAL INFORMATION

Medical diagnoses:

_____

Does the patient have any allergies? If so, what happens when exposed?:

_____

_____

Pt's Primary Care Physician: _____

Address/Phone Number: _____

Pt's Specialist Physician if applicable: _____

Address/Phone Number: _____

Current Medications:

NAME	DOSAGE	FREQUENCY	METHOD

***IF YOU NEED MORE ROOM PLEASE FILL IT OUT ON THE BACKSIDE**

Any recent psychological testing?

_____

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Professional Psychologist administering testing: _____

Copy of results available? ☐ YES ☐ NO

Hospitalizations/Surgeries: _____

_____

_____

Any Equipment used/necessary? ☐ YES ☐ NO

If yes, please list: _____

_____

PSYCHOLOGICAL INFO:

Any history of substance abuse? ☐ YES ☐ NO

Any history of trauma or abuse? ☐ YES ☐ NO

Have you had suicidal thoughts recently? ☐ NEVER ☐ RARELY ☐ SOMETIMES ☐ FREQUENTLY

Have you had them in the past? ☐ NEVER ☐ RARELY ☐ SOMETIMES ☐ FREQUENTLY

Have you intentionally inflicted any harm upon yourself? ☐ YES ☐ NO ☐ UNSURE

If yes, how? ☐ CUTTING ☐ SUICIDE ATTEMPT ☐ OTHER (specify):

_____

_____

_____

_____

_____

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One a scale of 1-7 with 7 being the highest, how happy do you consider yourself and why?

Minors only: Have there been individualized education plans (IEP), section 504 plans, or accommodation plans put in place at school? Do you have any evaluation results or reports from school that present a concern for you? If so, please explain in detail.

Are you a survivor of any type of trauma? For example, BUT NOT limited to: Miscarriage, loss of infant/child, foster/adoption incidence, pregnancy/birth complications, accident of any kind, relationship abuse (emotional, mental, physical), child abuse (emotional, mental, physical), experience a natural disaster, sexual abuse of any kind such as rape or molestation, etc. If so, please explain.

What are you hoping to accomplish in therapy?

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Any concerns or fears about therapy?

What is your greatest strength?

How would you describe your religious or spiritual beliefs and practices (if any)?

OTHER

Who lives in the home with the patient:

Does the patient live in two homes? ☐ YES ☐ NO

If yes, explain: _____

Are there any stairs in the home? ☐ YES ☐ NO

Is your child in school? ☐ YES ☐ NO

If so, what grade? _____

Name of School and District:

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Does your child receive therapy in school? ☐ YES ☐ NO

If so, please list:

TYPE OF THERAPY	FREQUENCY	THERAPIST NAME

Is your child in a mainstream classroom? ☐ YES ☐ NO

If no, please explain: _____

Does your child receive any other therapy at this time? ☐ YES ☐ NO

Please explain (discipline and therapist name):

_____

TELL US A FEW OF HIS/HER FAVORITES

Favorite color: _____ Favorite Character/Toy: _____

Favorite music:_____

Favorite Movie/TV Show: _____

Hobbies/Interests:_____

Favorite Food: _____

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Favorite Candy: _____

Any additional information to add: _____

_____

_____

CLIENT PRINT NAME CLIENT SIGNATURE DATE

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