Neuro therapeutic
Pediatric Therapies Inc

Confidential Information and History-Child

All information disclosed to Neurotherapeutic Pediatric Therapies' staff is confidential, except when a child is in danger of abuse or suicide, is a clear and present danger to their-self or others or is the victim of a crime. An authorization for release of information must be signed by a parent or youth before information can be given to the court, school, or third party in any other case not mentioned above.

Please complete this form as applicable.

Today's Date _____

CLIENT INFORMATION

Legal First Name: _____ Legal Last Name: _____

Preferred Name: _____ DOB *(mm/dd/yyyy)*: _____

CURRENT PROBLEMS

Please describe briefly what changes you are hoping to make by starting services now.

Please mark only the symptoms below which the client has experienced in the past 3 months.

- ☐ Relationship Issues
- ☐ Depression
- ☐ Obsessions or compulsions
- ☐ Trouble concentrating
- ☐ Memory problems/confusion
- ☐ Weight changes
- ☐ Self-esteem problems
- ☐ Anger/irritability
- ☐ Feeling anxious
- ☐ Lack of motivation
- ☐ Physical complaints of pain
- ☐ Social discomfort
- ☐ Hearing voices
- ☐ Racing thoughts
- ☐ Other: _____
- ☐ Computer addiction
- ☐ Feeling hopeless
- ☐ Parenting issues
- ☐ Extreme sadness/crying spells
- ☐ Lack of energy
- ☐ Feeling stressed
- ☐ Feeling guilty
- ☐ Feeling fearful
- ☐ Acting violently
- ☐ Fatigued
- ☐ Thoughts of/attempts to hurt yourself/others
- ☐ Muscle tension
- ☐ Visual hallucinations
- ☐ Wide mood swings
- ☐ Recurring, intrusive thoughts/memories
- ☐ Problems with pornography
- ☐ Change in sleeping habits
- ☐ Change in eating habits
- ☐ Feelings of extreme happiness/excessive energy
- ☐ Change in sexual interest or function
- ☐ Problems getting along w/others
- ☐ Trouble performing at school
- ☐ Lack of enjoyment of usual activities
- ☐ Sudden feelings of panic
- ☐ Thoughts of killing yourself/others
- ☐ Flashbacks
- ☐ Suspicion/paranoia
- ☐ Nightmares

Has the client ever thought of/attempted to hurt themself/others? ☐ No ☐ Yes If yes, explain:

_____

Has the client ever thought of/attempted suicide? ☐ No ☐ Yes If yes, explain:

_____

Has the client ever been diagnosed or treated for an eating disorder? ☐ No ☐ Yes If yes, explain:

_____

SOCIAL

Spiritual? Religious? Church/Spiritual Community? ☐ No ☐ Yes If yes, how important is it?

_____

Does the client have social support? ☐ FAMILY ☐ NEIGHBOR ☐ FRIENDS ☐ CO-WORKERS ☐ OTHER: _____

If so, who?

What are the hobbies/activities that the client finds pleasure in?

MEDICAL INFORMATION

Past/current medical problems/surgeries:

Were developmental milestones met appropriately (i.e., sitting up as infant, walking, talking on time with average child development)? ☐ Yes ☐ No If no, please describe:

Preferred Pharmacy: _____

Is the client sexually active? ☐ No ☐ Yes

If Applicable:

Any problems with menses? ☐ No ☐ Yes Date of last menstrual period? _____

Has the client ever been pregnant? ☐ No ☐ Yes

PREVIOUS MENTAL HEALTH TREATMENT

Outpatient: ☐ No ☐ Yes Inpatient ☐ No ☐ Yes

Drug/Alcohol: ☐ No ☐ Yes Group: ☐ No ☐ Yes

Has the client or their family ever attended therapy/counseling before? ☐ No ☐ Yes If yes, please describe below:

1. Name of therapist/counselor/agency _____

   Did client go alone or with family? _____Dates: _____

   Reason: _____

2. Name of therapist/counselor/agency _____

   Did client go alone or with family? _____Dates: _____

   Reason: _____

FAMILY MENTAL HEALTH HISTORY

Describe any mental health issues within the client's immediate family:

_____

Are any of the client's family members frequent drug or alcohol users? ☐ No ☐ Yes, If yes, which members?

_____

SUBSTANCE USE HISTORY

During the PAST 12 MONTHS, on how many days did the client... (Put "0" if none).

Drink more than a few sips of beer, wine, or any drink containing alcohol? _____

Use any tobacco (smoking, vaping, chewing)? _____

Use any marijuana? _____

Use anything else to get high (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)? _____

Amount of caffeine consumption: _____

LEGAL HISTORY

Has the client ever been convicted of a misdemeanor or felony? ☐ No ☐ Yes If yes, explain

_____

Please list any previous charges or arrests (include runaway, curfew violation, MIP, etc.):

_____

Number of arrests/charges in the last 24 months: _____

Have any of these charges been drug/alcohol related? _____

Are the client's parents currently involved in divorce or child custody proceedings? ☐ No ☐ Yes Previously? ☐ No ☐ Yes

If yes, please explain: _____

Is DHS Involved? ☐ No ☐ Yes If yes, why?

_____

Is the client court ordered to attend Mental Health Treatment? ☐ No ☐ Yes