Children's Psychological Services, LLC

www.mychildpsych.com
941-877-0284

New Client Information

Name of Child _____Date of Birth _____ Age____

Parent/Legal Guardian Name _____

Parent/Legal Guardian Email Address_____

Phone Number (Primary) _____(Secondary) _____

Home Address _____

Primary way to be contacted ☐ Phone ☐ Email ☐ Text

Is it ok to leave a voicemail ☐ Yes ☐ No

Primary Language at Home _____

Siblings and their ages_____

Any custody agreements pertaining to this child?_____

School Information

School Name_____ District_____

Teacher Name_____Grade_____

Has the student been retained? (What grades?)_____

Number of days absent this school year?_____

Are you concerned with behavior at school? If yes, please explain

Does your child have an active Individualized Education Plan (IEP), Educational Plan (EP), or Section 504 Plan? ☐ Yes ☐ No

If yes, which program?_____
*Please provide a copy of the most current IEP, EP, or 504, if possible.

Current report card grades_____

Current standardized test scores (FSA, SAT-10)_____

Medical History

Any complications with pregnancy?_____

When did the child begin: crawling_____walking_____talking_____

Any known allergies?_____

Previous diagnoses?_____

Prior medical conditions?_____

Current medications?_____

Date and Results of last Vision Exam_____ Hearing Exam_____

Current Concerns for Child

Is your concern ____ academic ____emotional ____behavioral ____other

Current concern?_____

Previous treatment for this concern? _____

*If prior treatment was received, please provide the name(s) of prior therapists/psychologists seen

_____

Child's strengths_____

Child's weaknesses_____

Current Symptoms (Check all that apply):

☐ Anxiety ☐ Loss of Interest ☐ Impulsivity ☐ Peer Difficulties ☐ Appetite Issues
☐ Depression ☐ Sleep Changes ☐ Sleep Changes ☐ Defiant Behavior ☐ Irritability

Additional Comments:

Date Intake Occurred_____