

Client Information (Child/Adolescent)

Today's date: _____ Child's name: _____

Person completing this form and relationship to child: _____

Are the child's parents divorced? Yes* No

**If yes, parent must produce a copy of the divorce decree indicating that he or she has the right to bring the child for treatment.*

Demographic Information

Date of birth: _____ Age: _____ Sex: _____

Home street address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Email: _____

People child lives with (names, ages, relationships): _____

Presenting Concerns

What are the difficulties that you brought you here? _____

What do you hope to gain from treatment? _____

Jill Racine, PhD
Licensed Clinical Psychologist

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Father

Father's name: _____ Date of birth: _____ Age: _____

Cell phone: _____ Email: _____

Highest grade completed in school: _____ Year: _____ Major: _____

Father's employer: _____ Position: _____

Mother

Mother's name: _____ Date of birth: _____ Age: _____

Cell phone: _____ Email: _____

Highest grade completed in school: _____ Year: _____ Major: _____

Mother's employer: _____ Position: _____

Biological Family History

Name	History of mental illness?
Father: _____	_____
Mother: _____	_____
Sibling: _____	_____
Other: _____	_____

Medical Background

Child's pediatrician: _____ Date of last physical exam: _____

List any significant developmental delays: _____

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List any medical conditions or allergies your child has: _____

List any medications, including dosage and frequency, your child is *currently* taking: _____

Prior Counseling

List all prior counseling, mental health treatment, or psychiatric hospitalizations: _____

Was treatment helpful? Why or why not? _____

Education

School child attends: _____ Grade: _____

Does your child receive any school accommodations? If so, please describe: _____

Other

Is there anything else that would be helpful to know? _____

Symptom Checklist (Child/Adolescent)

Please check each item that describes a symptom you have experienced to any significant degree during the last month.

Physical Symptoms	Psychological Symptoms
<input type="checkbox"/> Allergies	<input type="checkbox"/> Academic difficulties
<input type="checkbox"/> Appetite change	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Backaches	<input type="checkbox"/> Apathy
<input type="checkbox"/> Cold hands and/or feet	<input type="checkbox"/> Bullies others
<input type="checkbox"/> Constipation	<input type="checkbox"/> Compulsive behavior
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Confusion
<input type="checkbox"/> Difficulty sleeping	<input type="checkbox"/> Cruel to animals
<input type="checkbox"/> Fatigue, lack of energy	<input type="checkbox"/> Crying spells
<input type="checkbox"/> Hair pulling	<input type="checkbox"/> Delusions (false ideas)
<input type="checkbox"/> Headaches [migraine or tension]	<input type="checkbox"/> Delusions (false ideas)
<input type="checkbox"/> Heart beats rapidly, even at rest	<input type="checkbox"/> Difficulty concentrating
<input type="checkbox"/> Jaw tension	<input type="checkbox"/> Disobedient/uncooperative
<input type="checkbox"/> Muscle cramps, spasms	<input type="checkbox"/> Feeling overwhelmed
<input type="checkbox"/> Nausea	<input type="checkbox"/> Forgetfulness
<input type="checkbox"/> Neck and shoulder pain	<input type="checkbox"/> Frequent irritability/Low frustration
<input type="checkbox"/> Nervous stomach	<input type="checkbox"/> Guilt
<input type="checkbox"/> Refusal to speak	<input type="checkbox"/> Hyperactivity
<input type="checkbox"/> Repetitive/recurrent behaviors	<input type="checkbox"/> Impulsivity
<input type="checkbox"/> Skin condition [e.g., rash]	<input type="checkbox"/> Intrusive, recurrent, unwanted thoughts
<input type="checkbox"/> Skin picking	<input type="checkbox"/> Irrational fears
<input type="checkbox"/> Speech difficulties	<input type="checkbox"/> Loneliness
<input type="checkbox"/> Stomach pain or ulcer	<input type="checkbox"/> Low self-esteem
<input type="checkbox"/> Tics	<input type="checkbox"/> Lying
<input type="checkbox"/> Tight muscles	<input type="checkbox"/> Mood swings
<input type="checkbox"/> Use of alcohol, cigarettes, or drugs	<input type="checkbox"/> Nightmares
<input type="checkbox"/> Weight change	<input type="checkbox"/> Sadness
<input type="checkbox"/> Wetting or soiling the bed	<input type="checkbox"/> School phobia/avoidance
	<input type="checkbox"/> Self-harm
	<input type="checkbox"/> Separation anxiety
	<input type="checkbox"/> Social difficulties
	<input type="checkbox"/> Suicidal ideation
	<input type="checkbox"/> Violent or destructive behavior

Other concerns: _____
