

Willows Edge, Inc.

CHILD PSYCHOSOCIAL REGISTRATION FORM

GENERAL INFORMATION:

Date: _____ Client: _____ M F Age: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Parent/Guardian Referring for Services: _____ Biological Mother Biological Father

Stepmother Stepfather Other: _____ If parents are divorced, who has legal, physical custody? _____

Parent/Guardian contact information:

Address: _____ City: _____ Zip: _____

Phone: _____ Cell Landline Email: _____

Phone: _____ Cell Landline Email: _____

Please star () preferred phone number for contact and messages*

Why are you seeking treatment at this time? _____

Please place a mark (x) to indicate the severity of your concerns?

Totally incapacitating		Extremely Severe		Severe		Moderate		Mild	No Problems
10	9	8	7	6	5	4	3	2	1

FAMILY HISTORY:

How many brothers and sisters does your child have? _____ Brothers _____ Sisters. What sibling order is your child (1st, 2nd, 3rd...)?

_____. Briefly describe how your child gets along with others in your family? (Brothers, sisters, parents): _____

Are there any family members you thought may have or have been diagnosed with mental health concerns? No Yes. If **yes**

please identify relationship and concerns (including ADHD, anxiety, depression, etc.): _____

Have any family members committed suicide? No Yes, Who? _____ Relationship _____ When? _____

Is there a history of drug and/or alcohol problems in the family? No Yes Who? _____

What substance? _____. Has your child witnessed or experienced any physical or emotional

abuse? No Yes, if yes, please explain: _____

Has your child ever been sexually abused? No Yes, if yes, please explain: _____

MEDICAL HISTORY:

Primary Care Physician: _____ Address: _____

Phone: _____ Current prescriptions or over the counter medications: _____

List any current health conditions: _____

How do you rate your child's general health? Poor Fair Average Good Excellent

Does your child have a history of Strep? No Yes

When was your child most recently diagnosed with Strep? _____

Has your child ever been diagnosed with Pediatric Autoimmune Neurologic and Psychiatric Disorders Associated with Strep (PANDAS)? No Yes

What treatment did your child receive related to PANDAS? _____

Has your child had any head injuries or loss of consciousness? No Yes, if yes please explain: _____

Does your child have difficulty falling asleep? No Yes. Staying asleep? No Yes. Does your child have nightmares or night terrors? No Yes. How often? _____

Have there been any changes in eating habits or appetite? No Yes. Any recent weight loss or weight gain? No Yes

Is there any other significant medical history not listed above? _____

CULTURAL, RELIGIOUS, SPIRITUAL INFORMATION:

Does your family identify with a particular ethnic group? No Yes (please name): _____

Does your family identify with a particular religious group? No Yes, which one? _____

Current spiritual preference: _____ Would you like to incorporate your religious/spiritual beliefs in counseling sessions? No Yes, if yes please describe: _____

EDUCATIONAL HISTORY:

What school does your child attend? _____ What grade? _____

Any Learning Disabilities? No Yes (please explain): _____

Does your child have a current Individualized Education Plan (IEP)? No Yes, if yes what school-based services does your child receive? OT PT Speech School Counseling Special Education: ___ Reading ___ Comprehension ___ Math ___

Other: _____ Any private services? No Yes, explain: _____

Check all that apply regarding your child's school experience: gifted classes School suspensions Conflicts with peers or teachers

DEVELOPMENTAL HISTORY:

Did you have a normal pregnancy and delivery? No Yes, explain: _____

Was your child born prematurely? No Yes, if yes, how many weeks gestation: _____

Were there any complications? No Yes, explain: _____

At what age did your child begin to walk? _____ At what age did your child begin to say single words? _____

Simple sentences/phrases? _____ Has there been a history of bed wetting? No Yes

Has there been a history of soiling or urinating in pants? No Yes

Does your child have frequent headaches or stomach aches? No Yes Who usually disciplines your child? _____

What disciplinary methods are used? _____

How does your child usually react to discipline? _____

SUBSTANCE USE HISTORY:

Has your child ever been arrested, convicted or placed on probation as a juvenile? No Yes, What age? _____

Offense: _____ Has your child tried using any illegal substances? No Yes, _____

PSYCHIATRIC HISTORY:

Does your child currently or in the past have a history of:

Suicide Attempts, when? _____

Suicidal Thoughts, when? _____

Has your child ever been hospitalized for psychiatric reasons? No Yes, Where and when: _____

Has your child been in counseling before? No Yes, What type and when? _____

Please check categories you are concerned about in your child: Depression Thoughts of Homicide Thoughts of Suicide

Anxiety/worried/nervous Sudden Mood Changes Overly Dependent Anger Control Problems Hallucinations:

__hearing voices __seeing things Not liking self Withdrawal from others Overly Suspicious, explain: _____

Problems with: __Parents __Siblings __Friends __Other Adults Poor Hygiene Overly sensitive to: __loud sounds

__textures __smells Obsessions or Compulsions Serious Trauma Self-Abusive Behaviors, explain: _____

Do you have any other concerns about your child's behavior?

Parent/Guardian Signature: _____ Date: _____

COUNSELOR USE ONLY

MENTAL STATUS

Appearance and Behavior:	<input type="checkbox"/> Clean <input type="checkbox"/> Neat <input type="checkbox"/> Unkempt <input type="checkbox"/> Disheveled <input type="checkbox"/> Other:
Looks stated age:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Younger <input type="checkbox"/> Older
Eye Contact:	<input type="checkbox"/> Appropriate <input type="checkbox"/> Inappropriate
Orientation:	<input type="checkbox"/> Time <input type="checkbox"/> Place <input type="checkbox"/> Person <input type="checkbox"/> Situation
Attention:	<input type="checkbox"/> Adequate <input type="checkbox"/> Inadequate <input type="checkbox"/> Other:
Perception:	<input type="checkbox"/> Adequate <input type="checkbox"/> Inadequate <input type="checkbox"/> Other:
Motor Activity:	<input type="checkbox"/> Normal <input type="checkbox"/> Slowed <input type="checkbox"/> Restless <input type="checkbox"/> Agitated
Thought Process & Content:	<input type="checkbox"/> Normal limits <input type="checkbox"/> Illogical <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinating _visual, _auditory, _tactile <input type="checkbox"/> Paranoid <input type="checkbox"/> Ruminative <input type="checkbox"/> Derailed thinking <input type="checkbox"/> Loose association
Cognitive Performance:	<input type="checkbox"/> Normal <input type="checkbox"/> Poor memory <input type="checkbox"/> Low self-awareness <input type="checkbox"/> Short Attention <input type="checkbox"/> Developmental disability <input type="checkbox"/> Poor concentration <input type="checkbox"/> Impaired judgment <input type="checkbox"/> Slow processing
Sensory Modulation Deficits:	<input type="checkbox"/> None <input type="checkbox"/> Speech <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Tactile <input type="checkbox"/> Taste

Risk Assessment: **Danger to:** None Reported or Observed **OR:** **Self:** Ideation Plan Intent
 Comments: Attempt **Others:** Ideation Plan Intent Attempt

Intervention(s)/Methods Provided:

Response to Intervention(s) and Development of goals and objectives:

Plan and Additional Information (recommendations, consultations):

Provider Signature: _____ Date: _____
Karen Smigelski, LPC, Supervisor