

Silber Psychological Services, P.A.

www.silberpsych.com

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Date of Appointment: _____ *for office use only* Tx: _____

PATIENT INFORMATION *for Child or Adolescent*

Child's Name: _____
First MI Last Name your child goes by

Child's Address _____
Street City State Zip

Child's Age: _____ Birthdate: _____ Is This Child Adopted? Yes No

Child's Home Phone Number: _____ Child's Cell Phone Number: _____

Sex assigned at birth: Male Female

Gender Identity: _____

Have you or a family member been here before? _____

SCHOOL INFORMATION

School Currently Attending: _____ Teacher: _____

Grade: _____ If this child has been retained, please indicate which grade: _____

PARENT INFORMATION	PARENT 1	PARENT 2
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- | | | |
|---|-----------|-----------|
| 1. Name: | 1. _____ | 1. _____ |
| 2. Age: | 2. _____ | 2. _____ |
| 3. Highest Education Level: | 3. _____ | 3. _____ |
| 4. Occupation: | 4. _____ | 4. _____ |
| 5. Place of Employment: | 5. _____ | 5. _____ |
| 6. Work Phone Number: | 6. _____ | 6. _____ |
| 7. Cell Phone Number: | 7. _____ | 7. _____ |
| 8. Home Phone Number, <i>if</i> different from child: | 8. _____ | 8. _____ |
| 9. Address, <i>if</i> different from child: | 9. _____ | 9. _____ |
| | _____ | _____ |
| 10. Primary E-Mail Address: | 10. _____ | 10. _____ |

	STEP-PARENT 1	STEP-PARENT 2
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- | | | |
|---|-----------|-----------|
| 1. Name: | 1. _____ | 1. _____ |
| 2. Age: | 2. _____ | 2. _____ |
| 3. Highest Education Level: | 3. _____ | 3. _____ |
| 4. Occupation: | 4. _____ | 4. _____ |
| 5. Place of Employment: | 5. _____ | 5. _____ |
| 6. Work Phone Number: | 6. _____ | 6. _____ |
| 7. Cell Phone Number: | 7. _____ | 7. _____ |
| 8. Home Phone Number, <i>if</i> different from child: | 8. _____ | 8. _____ |
| 9. Address, <i>if</i> different from child: | 9. _____ | 9. _____ |
| | _____ | _____ |
| 10. Primary E-Mail Address: | 10. _____ | 10. _____ |



REFERRAL INFORMATION

Who Referred you to our Practice? _____

How did you hear about our practice? (Check all that apply)

- Your doctor Your Child's Pediatrician Word of mouth A Therapist A Friend
- Phonebook Presentation / Talk by a therapist from this office Through Internet Search
- Other: _____

SIBLINGS: (List brothers and sisters by name and age)

MEDICAL INFORMATION:

Primary Care Physician: _____ Name of Practice: _____

Address: _____
Street City State Zip

Phone Number: _____

Medical Problems: (if none indicate "none") _____

Allergies: (if none indicate "none") _____

Hospitalizations/Surgeries: (if none indicate "none") _____

Medications:

- | | | | | |
|----|-------|--------------|-----------------|-------|
| 1. | _____ | Dosage _____ | # per day _____ | _____ |
| 2. | _____ | Dosage _____ | # per day _____ | _____ |
| 3. | _____ | Dosage _____ | # per day _____ | _____ |
| 4. | _____ | Dosage _____ | # per day _____ | _____ |

PRIOR PROFESSIONAL HELP: (Please list the names of other providers you have seen and approximate dates)

STRESSORS AFFECTING YOUR FAMILY IN THE PAST 1-2years:

- Births Job Change Separation Financial Issues
- Deaths Relocation Divorce Physical/Sexual Abuse
- Trauma School Marriage Substance Abuse
- Medical Bullying Stepchildren
- Other (Please list) _____

MAIN PROBLEM OR REASONS FOR SEEKING HELP:

Signature: _____ Date: _____

Relationship to Patient: _____