Silber Psychological Services, P.A.

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Cary, North Carolina 27511
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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
1. Name:	1._____	1._____
2. Age: 3. Highest Education Level:	2._____ 3._____	2._____ 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, ***if*** different from child:	8._____	8._____
9. Address, ***if*** different from child:	9. _____	9. _____
	_____	_____
10. Primary E-Mail Address:	10. _____	10. _____

	STEP-PARENT 1	STEP-PARENT 2
1. Name:	1._____	1._____
2. Age: 3. Highest Education Level:	2._____ 3._____	2._____ 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, ***if*** different from child:	8._____	8._____
9. Address, ***if*** different from child:	9._____	9. _____
	_____	_____
10. Primary E-Mail Address:	10. _____	10. _____

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

MAIN PROBLEM OR REASONS FOR SEEKING HELP:

_____

_____

_____

_____

_____

Signature: _____ Date: _____

Relationship to Patient: _____